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Senate

The Senate met at 10 a.m. and was called to order by the Honorable TOM UDALL, a Senator from the State of New Mexico.

PRAYER

The Chaplain, Dr. Barry C. Black, offered the following prayer:

Let us pray.

Our Father God, we thank You for this day, for eyes to see and for hearts to feel the wonders of Your world. Today, fill our Senators with a fresh faith and a triumphant confidence in Your final victory over the hearts of humanity. May our lawmakers face these sometimes baffling days with the glad assurance that no weapon that has been formed can prevail against Your eternal purposes.

Lord, help them to relinquish any negative thoughts to You and receive a fresh infusion of Your hope. Burn away the barriers to unity so that Your will can be done on Earth even as it is done in Heaven.

We pray in Your sovereign Name. Amen.

PLEDGE OF ALLEGIANCE

The Honorable TOM UDALL led the Pledge of Allegiance, as follows:

I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

APPOINTMENT OF ACTING PRESIDENT PRO TEMPORE

The PRESIDING OFFICER. The clerk will please read a communication to the Senate from the President pro tempore (Mr. BYRD).

The legislative clerk read the following letter:

U.S. SENATE,
PRESIDENT PRO TEMPORE,
Washington, DC, December 16, 2009.

To the Senate:

Under the provisions of rule I, paragraph 3, of the Standing Rules of the Senate, I hereby appoint the Honorable TOM UDALL, a Senator from the State of New Mexico, to perform the duties of the Chair.

ROBERT C. BYRD,
President pro tempore.

NOTICE

If the 111th Congress, 1st Session, adjourns sine die on or before December 23, 2009, a final issue of the *Congressional Record* for the 111th Congress, 1st Session, will be published on Thursday, December 31, 2009, to permit Members to insert statements.

All material for insertion must be signed by the Member and delivered to the respective offices of the Official Reporters of Debates (Room HT–59 or S–123 of the Capitol), Monday through Friday, between the hours of 10:00 a.m. and 3:00 p.m. through Wednesday, December 30. The final issue will be dated Thursday, December 31, 2009, and will be delivered on Monday, January 4, 2010.

None of the material printed in the final issue of the *Congressional Record* may contain subject matter, or relate to any event, that occurred after the sine die date.

Senators' statements should also be formatted according to the instructions at http://webster/secretary/cong__record.pdf, and submitted electronically, either on a disk to accompany the signed statement, or by e-mail to the Official Reporters of Debates at "Record@Sec.Senate.gov".

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By order of the Joint Committee on Printing.

CHARLES E. SCHUMER, *Chairman.*

● This "bullet" symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.

Mr. UDALL of New Mexico thereupon assumed the chair as Acting President pro tempore.

RECOGNITION OF THE MAJORITY LEADER

The ACTING PRESIDENT pro tempore. The majority leader is recognized.

Mr. REID. Mr. President, I suggest the absence of a quorum.

The ACTING PRESIDENT pro tempore. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. REID. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

SCHEDULE

Mr. REID. Mr. President, following leader remarks, the Senate will resume consideration of the health care reform legislation. The first hour will be equally divided and controlled between the two leaders or their designees. The majority will control the first 30 minutes and the Republicans will control the next 30 minutes. We expect a vote in relation to the Hutchison motion to commit today, and the Sanders amendment. It is my understanding Senator SANDERS will offer his amendment at around 11 o'clock today. They will both be pending. Senators will be notified as to when any votes are scheduled.

HEALTH CARE REFORM

Mr. REID. Mr. President, we continue making progress toward making it possible for every American to afford to live a healthy life. Senators continue to work together toward that goal because even though we may have differences of opinion on the details, we all share the strong belief in the differences we can make for the American people as it relates to their being healthy.

We all know our current system is beyond broken, and we know the citizens of this country demand that we fix it. We know this because they tell us—in letters, in phone calls, and visits we have at home, and we have not been going home very much, but certainly when we are able to get there. Those who oppose making health insurance more affordable and making health insurance companies more accountable would like you to believe that is not the case. But that is only propaganda by the insurance industry.

They want you to think the American people are happy when these greedy insurance companies deny health care to the sick and take away their coverage at the exact moment they need it the most.

They would like you to believe the American people do not mind hearing a multibillion-dollar company tell them: I am sorry you have diabetes. I am sorry you have a heart condition. But, also, it hurts my bottom line, so you are on your own.

These insurance companies and health care deliverers want you to believe that women gladly pay more than they should for the screenings they have to catch breast cancer, that men gladly pay more than they should to have the test to catch prostate cancer, and that seniors gladly pay much more than they should to get their prescription drugs.

Those who are trying to slow the Senate—and really the country—and stop reform want you to believe the American people do not mind paying hidden taxes to cover the uninsured, they do not mind the waste and fraud rampant in the health care system, and they do not mind losing their health insurance if they lose their job. But, simply, that is not true. That is not the case.

The people we represent—whether it is New Mexico, Montana; we have two from New Mexico, we have one from Michigan, one from Kentucky, Oklahoma—it does not matter what State you represent; there are stories.

Listen to what Mike Tracy, who lives in north Las Vegas, NV, said. His 26-year-old son has been an insulin-dependent diabetic since he was a baby. The insurance Mike's son gets through work will not cover his treatments, and the Tracys cannot afford to buy more coverage on their own.

But this family's troubles are about more than just money. Since they could not afford to treat their son's diabetes, it developed into something called Addison's disease—a disease that President Kennedy had. If you have money, you can treat the disease. If you do not, it is a very bad disease, likely could be fatal.

This is what Mike wrote me this past Friday.

> I don't know what to pray for first: that I will die before my son will so I don't have to bear the burden, or that I outlive him so I can provide support to his family when he is gone.

This should not be a choice for any American, and when given the chance to help people such as Mike, our choice should be easy.

Here is another example: Ellen O'Rourke wrote to me last Tuesday about her friends, the Hidalgos, who live in Incline Village, NV, a town on the shores of Lake Tahoe. The Hidalgos' 2-year-old daughter Lexie Mae has a cancer of the eye that could cost her vision or her life.

Lexie Mae's parents do not have health insurance and are counting on friends to help pay for their daughter's mounting medical bills. They are also counting on us to lower the cost of health care so they can afford their own. They work hard. They want health insurance. They cannot get it.

Another letter I got last week was from Elizabeth Parsons. She teaches music at an elementary school in Reno and volunteers after school at a dance and drama theater in town. She is 60 years old and wanted to retire at the end of this school year. But as she wrote me last Thursday.

> Unfortunately that plan has been postponed indefinitely for one reason only:
>
> ''one reason''—
>
> I can't afford to retire because of the skyrocketing increases in [my] health insurance.

Ms. Parsons has done a lot for her community. Now her country's leaders should do something for her: We should make sure her decision about whether to retire doesn't hinge on how expensive it is to keep her insurance.

A man named Walt Cousineau from Elko wrote me last Monday to tell me about his wife. She had a heart attack three Decembers ago. Health insurance companies are using that as an excuse to charge $2,000 a month for coverage, $25,000 a year. They call it a preexisting condition, a prior heart attack. She is not old enough yet for Medicare, but Walt is. He is 68. He had to go back to work so she could be put on his health insurance. Now Walt is asking us to go to work for him and asking us to make sure no one's health history can make staying healthy in the future more expensive.

Ken Hansen is from Mesquite, a town on the Arizona-Nevada border. He has chronic health problems and parts of his feet have been amputated. Ken can't go to a doctor because he makes too much to qualify for Medicaid and too little to afford private insurance. I wish to share with the Senate exactly what Ken wrote me:

> I am very frustrated because my only hope is that I die very soon because I can't afford to stay alive.

Those are his words—not my words—that his only hope is that he die. How can we look the other way? How can we possibly do nothing? This isn't about balance sheets or graphs or charts; it is not about contracts or fine print; it is not about politics or partisanship. This is about life and death in America.

Each story is more heartbreaking than the last. Each of these Nevadans has more than enough on his or her mind. Yet each of these citizens took time out of his or her day to beg their leaders to do something.

Mike Tracy, the father of the young man with diabetes and Addison's disease, ended his letter to me just a few days ago with this plea. Here is what he said:

> Democrats need health care. Republicans need health care. Independents need health care. All Americans need health care. Get it done.

We can't let them down. We just can't let them down.

Those trying to kill this reform have made it clear they will do anything to stop us. They can recite recycled talking points until their hearts' content, but that is it. But as long as Mike Tracy's son might die from a disease we know how to treat, we can't let these

obstacles stand in our way. As long as Lexie Mae's parents have to borrow from their friends to take their daughter to the doctor, we can't take no for an answer. As long as Elizabeth Parsons can't afford to retire, Walt Cousineau can't afford to stay retired, and Ken Hansen says he can't afford to stay alive, we can't stop fighting for them.

ESTATE TAX REFORM

Mr. REID. Mr. President, on a final point, for some time now we Democrats have been trying to reform the estate tax to avoid the train wreck that is coming next month.

Because of the legislation passed by the Republicans in 2001, the estate tax is repealed for 2010—gone, nothing. But because of the gimmick they used to pass this legislation, the estate tax returns in 2011, and it does so at the levels that were in effect in 2001.

This chicanery has created a nightmare for families trying to plan their affairs.

We have proposed a responsible path forward toward curing the estate tax problem. We proposed to extend the current tax parameters so that in 2010 couples would be able to pass down up to $7 million completely tax free. An estate tax at that level exempts all but the wealthiest two-tenths of 1 percent of estates from paying any estate tax.

The other side has rejected this reasonable approach. Instead, they want to keep the Bush tax law in place for 2010 as originally designed.

The irony in the Republicans' position is, it hurts the very families—small business men, women, and family farmers—whom they claim they are trying to help.

The surprise facing family farms and family-owned small businesses in 2010 is that repeal of the estate tax will actually increase their tax liabilities. These are families who would never pay the estate tax because they don't have assets totaling more than $7 million for a couple.

So why do they face a tax increase? It has to do with a provision in the Tax Code called stepped-up basis. What does this mean? The assets of family-owned businesses are often in the form of unrealized capital gains, the appreciation of the family business over time. Right now, until the end of this year, December 31, these capital gains are forgiven when a person dies—no capital gains at death and for these families with less than $7 million there is no estate tax under current law. Therefore, for these families, death is not a taxable event.

The capital gains tax is forgiven because the heirs to the property receive a step up in its basis for measuring tax liability when they ultimately sell the property.

The law my Republican colleagues insist go into place next month repeals stepped-up basis.

The bargain my Republican colleagues are advancing is simple. If you are rich, celebrate. If you are not, you should be afraid. If you are very wealthy, you get a huge windfall from repeal of the estate tax. If you are modestly successful—say you have a shoe store, a service station, a small farm, or whatever small business—but not to the point where you are facing an estate tax liability, your heirs will, nonetheless, face a tax increase because of the repeal of the estate tax.

For the wealthiest families in this country, they say don't worry about that. The estate tax is gone. For many more small businesses, Republicans say that is too bad. All these years, as Republicans were using family farms and small businesses as props in their zeal to repeal the estate tax, their real goal was protecting the wealthiest of the wealthy. The unfortunate aspect of that campaign is that repeal of the estate tax, even for just 1 year, will come at the expense of family-owned farms and small businesses.

We asked, last night, and it will be asked again by the chairman of the Finance Committee, the senior Senator from Montana, Mr. BAUCUS, to extend the estate taxes that now exist, giving a couple an exemption of up to $7 million for 2 months while we work things out on that and a number of other issues, but that has been rejected by my friends on the other side of the aisle.

I repeat: If the estate tax lapses for a period at the beginning of 2010, this will be a boon for the wealthy, a huge drain on the U.S. Treasury and, more importantly, let me also note that tens of thousands of middle-class families could suffer. If the estate tax lapses, even for a short period, these families will be subject to capital gains when they sell their inherited or bequeathed property, a process that will be enormously complicated for families who have no estate tax or planning issues today. Although this could be retroactively eliminated, in the meantime the uncertainty and planning around this would affect a large number of families who ordinarily don't have to think about the estate tax.

RECOGNITION OF THE MINORITY LEADER

The ACTING PRESIDENT pro tempore. The Republican leader is recognized.

ORDER OF BUSINESS

Mr. MCCONNELL. Mr. President, I would ask my colleague, the majority leader, was it his intention to propound a unanimous consent request on this issue?

Mr. REID. I say to my friend, the chairman of the Finance Committee will do that.

Mr. MCCONNELL. All right. I will go ahead and make my opening remarks. I don't know when the chairman of the Finance Committee wanted to make this request. Did he want to make a speech in connection with it as well?

The ACTING PRESIDENT pro tempore. The Senator from Montana.

Mr. BAUCUS. Mr. President, let me say to my friend from Kentucky, I will not make a lengthy speech, but I am more than prepared to wait until you give your comments, and when you conclude, I will make my request.

Mr. MCCONNELL. I would say to my friend from Montana, it would be helpful if you could go ahead and do the unanimous consent agreement, if you want to speak to the issue later.

Mr. BAUCUS. Well, other Senators wish to speak as well.

HEALTH CARE REFORM

Mr. MCCONNELL. Mr. President, reclaiming my leader time, the longer the debate over health care goes on, the clearer it becomes that the problem the Democrats are having isn't with some of the provisions we keep hearing about on the news; their problem is the fundamental opposition of the American people to the core components of the bill—the core of the bill.

Americans oppose the Democratic plan because they know the final product is a colossal legislative mistake. Not only does this bill fail to achieve its primary goal of lowering the cost of health care, it makes matters worse by driving up premiums, raising taxes, and wrecking Medicare for seniors.

The bill is fundamentally flawed, and the American people know it can't be fixed. That is why they are asking us to stop and start over with the kind of commonsense, step-by-step reforms that will address the cost problems.

Fortunately, a growing number of Democrats are beginning to listen to the voices of the American people. We have, just today, a Washington Post poll indicating, once again, the polls are unanimous that the American people are overwhelmingly opposed to this bill, and seniors in particular, by a very wide margin, do not favor this bill.

So our friends on the other side of the aisle face a choice. They can either side with those who are making a call to history or they can side with their constituents who say a vote on this bill would be a historic mistake.

That is what is unfolding behind the scenes: As a handful of Democratic leaders press ahead in a blind rush of frantic dealmaking to find 60 votes by Christmas, a handful of other Democrats are wondering which side they want to be standing on when the dust settles—with those who are pushing them to support a bill they don't like or with the American people who are imploring them not to do it.

This is an important moment in the life of our Nation. This is one of those moments when the free decisions of a handful of elected leaders are the only difference between America going down one road or another. History will be made either way. History will be made either way. But in this case, as in

many others from our history, Americans want history to show that a determined few took their side and triumphed over a powerful majority—a majority who clearly misread its mandate.

GUANTANAMO BAY

Mr. MCCONNELL. Mr. President, early yesterday, the administration announced what can only be viewed as the latest in a string of seriously misguided decisions related to the closing of the secure facility at Guantanamo Bay. It plans to move dozens of terrorist detainees from Guantanamo Bay Cuba to a prison in northern Illinois.

The explanation we used to get for moving detainees onto American soil was that Guantanamo's existence is a potent recruiting tool for terrorists. But even if you grant that, it is hard to see how simply changing Guantanamo's mailing address would eliminate the problem. Does anyone believe Al-Jazeera will ignore the fact that enemy combatants are being held on American soil? It is naive to think our European critics, the American left, or al-Qaida will be pacified by creating an internment camp in northern Illinois, a sort of ''Gitmo North'' instead of ''Gitmo South.''

As I said, this is just the latest in a series of misguided decisions. First, there was the decision to close Guantanamo by an arbitrary date without a plan for doing so. Americans expect their Government to protect them. That is why Americans overwhelmingly rejected the idea of closing Guantanamo.

Then there was the decision to bring the self-avowed mastermind of the 9/11 attack, Khalid Shaikh Mohammed, and his fellow 9/11 plotters into New York City for trial. We learned just this week, the administration plans to give other terrorists the benefits of a civilian trial in the United States.

Now there is this: According to the reports we have seen, the administration intends to bring as many as 100—100—foreign terrorist fighters from Guantanamo Bay to America, a plan that would make our Nation less safe, not more so. What is worse, the defenders of the proposal don't even seem to get the implications.

Rather than even attempt to reassure people about safety, politicians in Illinois are trumpeting this decision—get this now—as a jobs program, a jobs program. That is how out of touch they are. Democratic politicians are so eager to spin the failure of the $1 trillion stimulus, they are now talking about national security in the language of saved and created jobs.

The advocates of closing Guantanamo without a plan can't seem to make up their minds as to why it is a good idea. First, we were told we had to bring them here because Guantanamo is a dangerous symbol—the whole symbolism over safety argument. Now, with unemployment in double digits, it is being sold—incredibly—as a jobs project, some kind of shovel-ready plan.

But leaving aside the absurdity of marketing this as a jobs program, let's get to the core issue. The core issue is this: Moving some of the worst terrorists on Earth to U.S. soil on its face is more dangerous than leaving them where they are. Nobody could argue with that. Make no mistake, this decision, if implemented, will increase the threat to security at home. Let's count the ways in which it increases the threats of security in the United States.

There will now be another terrorist target in the heartland of America—an obvious one at that, right near the Mississippi River.

The FBI Director has already stated his concerns about the radicalization of other prisoners that could happen by moving terrorists here.

There is also the danger of detainees communicating with terrorists on the outside, as has happened in the past—a danger that would undoubtedly increase with the additional legal rights detainees will enjoy once they are moved into the United States.

Then there is the danger that the detainees could sue their way to freedom—yes, that the detainees could sue their way to freedom. Before the first detainee has even set foot in the United States, their lawyers stand ready to challenge in court the administration's decision to incarcerate detainees indefinitely in the United States. By purposefully moving detainees here, the administration is making it easier for detainees and their lawyers to succeed in doing so.

The Supreme Court has repeatedly held that foreign nationals have more rights if they are present on U.S. soil than if they are not. We have already seen the application of this principle. We have seen a Federal judge order detainees released into the United States—only to be reversed because the detainees at the time didn't enjoy the advantage of being present in the United States—an advantage the Obama administration intends to confer on them.

Then there is the case of the so-called shoe bomber, Richard Reid, who narrowly failed in his effort to blow up a passenger jet in midair. Americans might recall that Reid ended up in a supermax facility in Colorado. They might not recall what happened next. Not satisfied with his conditions of confinement, Reid sued the government. He said he wanted to be placed in less restrictive conditions where he could watch TV, order periodicals through the mail, and learn Arabic. He got his wish. The Obama administration acceded to Reid's demands. He has been placed in the general prison population, a less restrictive environment where he can speak to the media and where his visitors and mail will no longer be regularly monitored by the FBI. Is this how we should treat people who attempt to blow up commercial airliners? We will no longer have the FBI routinely monitor their mail? This is an outrage, an absolute outrage. Unfortunately, it is not an isolated case.

Just a few years ago, this same supermax allowed terrorist inmates to communicate with terrorist networks abroad. At the time, our Democratic colleagues criticized these security lapses harshly. The senior Senator from New York said Federal prison officials were ''incompetent when it comes to detecting possible terrorist activity in Federal prisons.'' He noted ''past evidence of terrorists communicating with live terror cells from inside prison walls.'' That was the senior Senator from New York.

Our Democratic colleagues now raise concerns about similar potential lapses at the proposed ''Gitmo North.''

This decision is ill-advised on multiple levels. It is also prohibited by law. Fortunately, if and when the Obama administration submits its plan for closing Guantanamo, Congress will have an opportunity to revisit the prohibition in current law that bars the transfer into the United States of Guantanamo detainees for the purposes of indefinite detention. That is against the law. At that point, we will decide whether this prohibition ought to be removed and whether millions of dollars ought to be appropriated to make this ill-advised decision a reality.

In short, Congress will have a chance to vote on whether we should treat the national security needs of the country as just another local jobs project. I suspect the American people will be no more supportive of this idea than they were of the administration's plan to close Guantanamo by an arbitrary date. Security can't take a backseat to symbolism, and it certainly should not take a backseat to some parochial jobs program.

I yield the floor.

RESERVATION OF LEADER TIME

The PRESIDING OFFICER (Mr. BEGICH). Under the previous order, leadership time is reserved.

SERVICE MEMBERS HOME OWNERSHIP TAX ACT OF 2009

The PRESIDING OFFICER. Under the previous order, the Senate will resume consideration of H.R. 3590, which the clerk will report.

The assistant legislative clerk read as follows:

A bill (H.R. 3590) to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

Pending:

Reid amendment No. 2786, in the nature of a substitute.

Hutchison motion to commit the bill to the Committee on Finance, with instructions.

The PRESIDING OFFICER. Under the previous order, the first hour will

be equally divided and controlled between the two leaders or their designees, with the minority controlling the first half and the majority controlling the second half.

The Senator from Montana is recognized.

Mr. BAUCUS. Under current law, the estate tax disappears next year—in 16 days—but snaps back to a 55-percent rate the year after. I believe that is not sound policy. The estate tax should not be zero in 1 year and then be snapped up to a very high rate in the subsequent year. As the Chair knows, current law has the rate slowly declining and the exemption slowly increasing. The individual exemption now is $3.5 million. If Congress takes no action, then beginning on January 1 of next year, that could be zero. The estate tax could be zero.

But another consequence that will occur too is that all heirs of the estate will find that the property they receive will be subject to a carryover basis. Currently, today, property received by heirs is subject to a step-up basis. They get the new basis and the value of the estate as of the date of the decedent's death. If this law expires, there would be no estate tax paid next year on any estate, but also the heirs will no longer have a step-up basis on the assets they receive.

There are several problems with letting the current law expire next year. One is the yo-yo effect. It is an outrage if Congress allows estate taxes to change so much, particularly near the end, that is, a lower rate this year with an expiration to a zero rate next year, and also changing a step-up to a carryover basis, and the following year up at a much higher rate.

The second problem, frankly, is I do think there should be an estate tax on the highest value estates. I think that is good policy.

Third, people don't talk much about this, but I think we should focus on it. If current law expires, every heir will be subject, as I said, to a carryover basis in determining his or her taxes when that taxpayer, the heir, at a later date sells the property and has to pay capital gains. What are the problems with that? First of all, massive recordkeeping confusion—massive.

Soon, I am going to propose an extension in the current law. If that is not passed and if we do not extend the estate tax law, all taxpayers, all heirs, will be subject to massive confusion in trying to determine the value of the underlying assets when they later try to sell. The value of the step-up basis to the heir obviously is a lower capital gains tax, but there is also certainty. People pretty much know the value at the death of the decedent.

I cannot emphasize strongly enough how much confusion there will be on January 1, if my consent is not agreed to. There will be such confusion because of the heirs receiving property subject to a carryover basis, not a step-up basis, let alone the capital gains tax they will have to pay when they sell that capital asset at a subsequent date. Currently, when the heir receives that capital asset, because it is a step-up basis, there is much less capital gain paid, presumably, by that heir who sells the asset.

Here it is mid-December. The only responsible thing to do to prevent the yo-yo effect—how in the world can people look at planning in their estates if the law goes up and down and changes all the time? It has kind of leveled off, as I said, at the 2009 rates and people have a pretty good idea what those are. Some in this body would like to see the rate go lower and exemptions go higher. Some in this body would like to see other changes. We kind of leveled off at 2009 estate tax laws, where the rates are set and the exemptions are set. Most people in the country are anticipating Congress will eventually pass that.

It would be irresponsible to further the yo-yo effect by allowing current law to expire and create all this massive confusion, this chaos that will apply to heirs of the estates on January 1 because of this change in capital assets from step-up to a carryover basis, among other things.

UNANIMOUS CONSENT REQUEST—H.R. 4154

Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of H.R. 4154, which was just received from the House and is at the desk; that the Baucus substitute be considered and agreed to, the bill, as amended, be read the third time and passed, the motion to reconsider be laid upon the table; that any statements relating to the measure be printed in the RECORD without any further action or debate.

The PRESIDING OFFICER. Is there objection?

Mr. MCCONNELL. Mr. President, reserving the right to object, there is nothing more outrageous to the American people than the thought that they will have to visit both the IRS and the undertaker on the same day.

Surveys indicate that Americans, even after informed that estate tax may not apply to them, object to it in principle.

I am going to ask that the chairman of the Finance Committee modify his request in the following way:

That there be an amendment considered that reflects a permanent, portable, and unified $5 million exemption that is indexed for inflation, and a 35-percent top rate; and further, that the amendment be agreed to, the bill then be read the third time and passed, with the motion to reconsider laid upon the table.

Before the Chair rules, I want to acknowledge my good friend Senator KYL, the Republican whip, who has been our leader on this side of the issue. He has crafted a proposal, along with the leader on this on the other side, Senator LINCOLN of Arkansas, that is consistent with the consent agreement and with the modification I am now asking the chairman of the Finance Committee to make. This approach would provide certainty and clarity to all taxpayers, especially small businesses and farmers; whereas the UC propounded by the chairman would only create additional confusion, with three different rates coming into effect in the course of a 12-month period.

Summing it up, I ask that my friend from Montana modify the agreement in the way I described.

Mr. BAUCUS. Mr. President, I don't think this is the way to do business here; that is, to enact estate tax law here on the floor of the Senate without any notice, and also because there are so many considerations Senators on both sides want to look at. It would be improper. I object.

Mr. MCCONNELL. I object.

The PRESIDING OFFICER. Objection is heard.

Mr. BAUCUS. Mr. President, I yield 5 minutes to the Senator from New Mexico.

The PRESIDING OFFICER. The Senator from New Mexico is recognized.

Mr. BINGAMAN. Mr. President, let me speak in support of what Senator BAUCUS, the Senator from Montana, attempted to do just now—to get a short-term extension of current law with regard to the estate tax, so we would have a $3.5 million exemption from the estate tax into next year for a short period, while we actually settle on what type of permanent change in estate tax law is appropriate.

As the Senator from Montana pointed out, the circumstance we find ourselves in right now, given the current state of the law, is untenable and irresponsible. What the current status is that if a person dies in the next 16 days, if their estate exceeds $3.5 million, they will be subject to an estate tax, and a couple whose estate—when the second member of the estate dies and their estate would exceed $7 million, they would be subject to an estate tax.

After the next 16 days, beginning on January 1 of next year, we have no estate tax under the law as it now exists. But at the end of next year—or the beginning of 2011—the estate tax comes back at a 55-percent rate.

That is not a reasonable set of circumstances for the American public to have to face. Not only is it a 55-percent rate that comes back on January 1, 2011, the exemption—the amount that is exempt from the estate tax—is reduced to $1 million. That is, obviously, adverse to many families in this country.

What has happened on the Senate floor is that the Senator from Montana has said let's do a short-term extension of the current estate tax provisions for a few months and get a resolution of what should be done on a permanent basis. The Republican leader has said: No; here is a permanent solution. Take this permanent solution or we object.

That is not a responsible way for this body to proceed, in my opinion. I do

think this issue that both Senator REID and Senator BAUCUS have spoken about of this problem with a stepped-up basis going away for inherited assets is a very real problem. It is arcane, I understand that. It sounds like accounting speak. But it is a very real problem for American families when they inherit property in the future to have to take the value for purposes of paying capital gains tax. If that property is ever sold, they will have to go back and try to determine what was the basis that their parent or the person from whom they inherited the property had in that property. It is a bookkeeping nightmare and will create great confusion for American families.

Clearly, the right course is for us to do a short-term extension of the current estate tax provisions and then get agreement between the two parties as to what a long-term solution could be in the next couple of months.

That course, evidently, is being blocked. The request was made yesterday, I understand, by Senator PRYOR to have a short-term extension. The Republican leaders objected to that request. The same objection has been raised to the request by Senator BAUCUS today.

I do think this is an unfortunate circumstance. It is a great disappointment to me to see us doing business in this fashion. I know there are many who think there should be no estate tax. I do not agree with that perspective. The estate tax in my State—I went back and got the IRS figures. There were 80 individuals in the year 2008 who wound up having to pay some estate tax, whose estates had to pay some estate tax in the State of New Mexico. It does not apply to most individuals.

I do believe it is appropriate that there be an estate tax for large estates. I do believe we should have a consistent policy, and it should not be something that is here today, gone tomorrow, and back again in a much worse form at the beginning of January 2011. That is the course we are on today. I think it is very unfortunate.

Again, I strongly support what the Senator from Montana was trying to accomplish with his unanimous consent request.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, I ask unanimous consent that Senator KYL be permitted to speak for up to 5 minutes and that following his remarks, the hour of controlled time on the health care legislation begin.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from Arizona.

Mr. KYL. Mr. President, the argument that the chairman of the Finance Committee made reminds me of a story told in law school of the fellow accused of murdering his parents. He pled for mercy on the court since he was an orphan.

I asked the chairman of the committee numerous times this year to address this problem, and the response always was: We are too busy. We are too busy with health care was the usual response. Now we find ourselves at the end of the year, and it is odd that the chairman argues that we have a big emergency on our hands and we have to act.

It is not as if we have not known this issue was out there. Nor, as Senator BINGAMAN just suggested, has it been a big mystery that the rate on the estate tax was going to go to zero next year. That is the 2001 law. We have known that for years.

Frankly, people have applauded the fact there is not going to be an estate tax next year. The only problem is if the people on the other side of the aisle intend to repeal that law so we do have an estate tax. I know that is their intention. They are creating the confusion because the law has been known about for 10 years that we are going to have a zero rate. Now all of a sudden they say we cannot let that happen. We are going to have to change it next year. Since we think we may be able to do that, we should extend what we have right now and not let the zero rate take hold.

I suspect the great dilemma that is being posed is one most folks would love to have as a problem. The dilemma being proposed is that if the rate goes to zero and the heirs of the property decide to sell the property at some point, they will have to pay a capital gains tax. That is just fine. That is what most people would like to do.

Since this income is taxed twice—it is taxed once when you make the income, then it is taxed again if you have any of that left over when you die—that is unfair. What we have always argued is that the estate tax, therefore, should go away and just leave the existing Tax Code where it is, which says: If somebody inherits property and later sells that property, sure, they should pay a capital gains tax on it. I would think most people would think that is a pretty good deal.

The capital gains tax is 15 percent; whereas the estate tax under the proposals of my friend from Montana would go to 45 percent. As between paying 45 percent and 15 percent, I think it is pretty clear what most small business folks and farmers would like to do.

Of course, the original basis of the property is the basis for paying the tax. Again, if you put that question to small business folks or farmers, they would tell you they would rather pay the capital gains tax than they would an estate tax of 45 percent.

Mr. President, I ask unanimous consent to have printed in the RECORD at the conclusion of my remarks an editorial from the Wall Street Journal from December 11 called, ''The Tax That Won't Die, Death Blow, Night of the Living Death Tax, Estates of Pain.''

The PRESIDING OFFICER. Without objection, it is so ordered.

(See exhibit 1.)

Mr. KYL. Mr. President, among the things pointed out in this editorial, they say:

> We've long argued that the economically optimal and fairest death tax rate is zero. The tax is applied to income that was already taxed when it was earned, so it is a double tax on savings and capital. The correct way to tax a gain in the value of assets bequeathed to an heir is with a capital gains tax of 15 percent when the assets are sold, rather than at the time of the funeral of the original owner.

I think that says it all. I hope the problem my friends are so concerned about—first of all, they recognize a problem they themselves manufactured by not getting around to doing anything about this until the eleventh hour. Second, it is a problem that does not have to exist if they will leave the existing law alone and let the rate go to zero, which is what everybody wants it to be.

Sure enough, if your heirs sell property after that, they will have to pay capital gains. Ask them what they would rather do—pay a 15-percent rate or a 45-percent rate. I think the answer to that is pretty clear.

EXHIBIT 1

[From the Wall Street Journal, Dec. 11, 2009]

THE TAX THAT WON'T DIE

Well, the moment of truth has arrived, and House Democrats recently voted 234–199 to cancel the 2010 repeal and hold the rate permanently at 45% with a $3.5 million exemption. Senate Majority Leader Harry Reid now wants to do the same. But to suspend the Senate's health-care debate and turn to the estate tax, he needs 60 votes. All Republicans and some Democrats are saying no. Blanche Lincoln of Arkansas and Jon Kyl of Arizona will accept no more than a 35% permanent rate with a $5 million exemption.

We've long argued that the economically optimal and fairest death tax rate is zero. The tax is applied to income that was already taxed when it was earned, so it is a double tax on savings and capital. The correct way to tax a gain in the value of assets bequeathed to an heir is with a capital gains tax of 15% when the assets are sold, rather than at the time of the funeral of the original owner.

Study after study, including one co-authored years ago by White House economist Larry Summers, finds that a powerful motivation for entrepreneurs to grow their businesses is to pass that legacy to their children. The left disparages this as building ''family dynasties,'' but most Americans think that it is immoral for the government to confiscate the fruits of a life's effort merely because of the fact of death.

Democrats also say their rate would apply only to the richest 2% of estates. But a new study by economists Antony Davies and Pavel Yakovel of Duquesne University finds that the estate tax ''impacts small firms disproportionately versus large firms'' by encouraging well-capitalized companies to gobble up smaller ones at the owner's death. The study shows the result is to ''promote the concentration of wealth by preventing small businesses from being passed on to heirs.''

Republicans and willing Democrats shouldn't give up on eliminating the death

tax. The Kyl-Lincoln amendment to create a permanent 35% rate is far better than the confiscatory House bill. But the best strategic outcome now is to let the death tax expire in January as scheduled under current law, and return to this debate next year when the tax rate is zero. Then let liberal Democrats explain to voters on the eve of elections that they must restore one of the most despised of all taxes.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, clearly, the right public policy is to achieve continuity with respect to the estate tax. If we do not get the estate tax extended, even for a very short period of time, say, 3 months, we would clearly work to do this retroactively so when the law is changed, however it is changed, or if it is extended next year, it will have retroactive application.

The uncertainty for tens of thousands of middle-class families needs to stop. That is why retroactive application of anything that passes next year makes sense.

Right now, 99.7 percent of estates do not have to worry about the estate tax. If we do not extend current law, many heirs are going to have to worry about capital gains. There is the potential for high-income households to take advantage of the temporary reductions in the rates for gift taxes and temporary elimination of GST to do massive estate planning—potentially benefiting those households by billions of dollars at the expense of U.S. taxpayers. Beyond this, what Congress is doing is a huge benefit for lawyers and accountants who do all the estate planning.

The right thing to do is to extend current law for a brief period of time to get our act together to decide what estate laws should be. That is the right thing to do. I am very disappointed that the other side of the aisle does not let us do the right thing—at least extend current law for a while until we know what the estate tax law should be.

Mr. COBURN addressed the Chair.

The PRESIDING OFFICER. The Senator from Montana has the floor.

Mr. BAUCUS. Mr. President, for the benefit of Senators, we are now back on the health care bill. Let me lay out today's program.

It has been nearly 4 weeks since the majority leader moved to proceed to the health care reform bill. This is the 16th day that the Senate has considered the bill.

The Senate has considered 23 amendments or motions and conducted 18 rollcall votes.

Today the Senate will debate the motion to commit regarding taxes offered last night by the Senator from Texas, Mrs. HUTCHISON. Under the previous order, later this morning, we expect that the Senator from Vermont, Mr. SANDERS, will offer his amendment No. 2837 on a national single-payer system.

This morning, the first hour of debate will be equally divided and controlled between the two leaders or their designees. The majority will control the first half hour and the Republicans will control the second half hour.

We expect the Senate to conduct votes today in relation to the Hutchison motion and the Sanders amendment.

Also, today, the House of Representatives is scheduled to act on the Department of Defense Appropriations Act which also contains a number of vital year-end measures. We look forward to receiving that measure in the Senate as well.

I yield 10 minutes to the Senator from Ohio and then 15 minutes to the Senator from Delaware.

The PRESIDING OFFICER. The Senator from Ohio.

Mr. BROWN. Mr. President, I thank Senator BAUCUS for yielding, and I thank Senator KAUFMAN also for him yielding.

Less than 5 percent of cancer patients enroll in clinical trials. Only 6 percent of people who suffer from severe chronic illnesses participate. These low participation rates mean it is harder to conduct a timely trial. In fact, delays in patient recruitment for clinical trials account for an average of almost 5 months lost per trial. Nearly 80 percent of trials run over schedule by more than a month. Only 6 percent are completed on time.

Clinical trial delays lead to treatment development delays, whether it is the next breakthrough drug or some other lifesaving therapy. Without clinical trials, medical innovation would come to a halt.

Unfortunately, one major reason more patients do not enroll in clinical trials is that their insurance company coverage discourages it.

Insurers today take advantage of lax regulations that allow them to deem all care for a person in a clinical trial as ''experimental''—even routine services they would get if they were not in the trial, such as x rays, blood tests, and doctor visits.

This draconian policy predictably scares many patients away from potentially lifesaving trials. Patients simply cannot afford to pay out of pocket for all of their own care. Understand, they do not expect the insurance company to pay for the trial itself. No one is suggesting that. No one thinks that. But insurers should not be allowed to use a patient's participation in a clinical trial as an excuse to deny them coverage for standard care.

To address this problem, Senator HUTCHISON of Texas and I have filed amendment No. 2871. This amendment would require all insurance companies to simply live up to the promises they have made to their premium-paying policyholders. It means covering the cost of routine care for clinical trial participants.

More than 30 States have already enacted a similar clinical trials policy for their State-regulated insurance plans. Medicare has already enacted a similar clinical trials policy for its beneficiaries. The VA and DOD have already enacted similar clinical trials policies for their members. Even some insurance companies are already doing the right thing in covering the routine costs associated with clinical trials.

But because many are not and because there is no standard criterion by which appeals can be adjudicated, countless patients who would otherwise enroll in clinical trials do not.

Take, for example, Sheryl Freeman from Dayton, OH. Sheryl and her husband Craig visited my office in Washington in 2007. Sheryl was a retired teacher suffering from multiple myeloma. Thankfully, she had health insurance through her husband's employer. Yet when Sheryl tried to enroll in a promising clinical trial at James Cancer Hospital at Ohio State, her insurance company balked, refusing to cover the routine care costs.

Understand this: She had insurance, she had good insurance—she thought she had good insurance. She enrolled in a clinical trial paid for by the people doing the clinical trials—the hospital, the drug company, whomever. But the insurance company pulled back and said: We are not going to cover routine care for her anymore since she is in a clinical trial, something she was entitled to with or without the clinical trial. Regardless of whether or not Sheryl enrolled in a clinical trial, she still needed to visit her oncologist in Dayton once a week for standard cancer monitoring, including scans and blood tests. But her insurance company would stop covering these services if she enrolled in the clinical trial.

Sheryl wanted to enroll in a clinical trial because she hoped it would save her life. She hoped it would give her more time with her loved ones. She hoped it would help future patients diagnosed with the same type of cancer, but she was not willing to force her family into bankruptcy. So instead of devoting her energy toward combating cancer, Sheryl spent the last months of her life haggling with the insurance company. By the time her insurance company relented, it was too late. Sheryl died December 7, 2007.

Sheryl's husband Craig, with whom I have spoken a couple of times and met with, wrote the following about the ordeal:

> No patient should have to fight insurance when battling a disease such as cancer.

How many times have we heard that in this Chamber? Tragically, Sheryl's experience is not an isolated case.

In Ohio—my State—one cancer hospital has reported that over one-third of patients who tried to enroll in a clinical trial over a 6-month period were automatically denied access by their insurance company. Again, I understand how that happens. You have decent insurance, you think. Then you decide to enroll in a clinical trial that your doctor suggests. The insurance company then quits covering you for the things it used to cover you for—the routine care you need as a patient.

Take Gene Bayman. I met and talked to Gene—a courageous man who loved his family. His family was so fond of him, as you could see, when I saw him in Columbus with his family. He was diagnosed in February 2007 with multiple myeloma. Gene's doctor recommended a combination of standard treatment and clinical drugs, but Gene's insurance company threatened to stop paying for the routine care otherwise covered under the policy if he enrolled in the clinical trial.

If that is not rationing, Mr. President, I don't know what is.

Gene died in June of this year, never having the chance to participate in the cutting-edge research that might have saved his life. Gene wrote, before he died:

I don't want my health options limited by insurance companies concerned with the bottom line rather than the medical research my doctor prescribes.

Mark Runion, also from Ohio, faced the same barrier. Mark was being treated for multiple myeloma with standard care—a stem cell transplant and chemotherapy. His doctor recommended he enroll in a clinical trial to try out a new drug that might help him recover quickly. The insurance company refused to comply, telling Mark if he were to enroll in the clinical trial they wouldn't pay for any of his cancer care. Another terrible lost opportunity. The clinical trial would have helped us learn more about which drugs we should administer to patients after stem cell transplants. In other words, while this most directly, most tragically, most painfully affected Mark Runion and his family, it also affects all of us who have loved ones or who might ourselves come down with this disease. The clinical trial that Mark wanted to enroll in would have given him an opportunity and would have given all of us more scientific knowledge and information that would have been helpful.

Instead, the insurance company took a shortsighted view and denied Mark the recommended care. Mark writes:

I personally would rather make my medical decisions with my doctor—the expert in my care—rather than my insurer.

These stories should have ended differently. Sheryl, Gene, and Mark all paid premiums to health insurance for years. But when they got sick and were referred to a clinical trial, the insurance company refused to pay for the benefits guaranteed under its policy.

Health insurance reform should be about making sure insurance companies can't renege on their commitments. It is about ensuring that insurance companies can't write sham policies that allow for rescissions and riders and exceptions and bring about more horror stories than we all care to recount. It is about closing loopholes that health insurance companies are great at taking advantage of, and as some say, staying one step ahead of the sheriff.

This amendment is consistent with those goals. It would help advance important research in the most serious diseases. This is a public health issue for all of us.

In closing, if we are ever going to find a cure for cancer and diabetes and cardiovascular disease and Alzheimer's and ALS and the hundreds of other diseases killing millions of Americans each year, we need to encourage in every way possible participation in clinical trials and not put up barriers against participation.

This amendment is endorsed by the Lance Armstrong Foundation, the American Academy of Pediatrics, the Susan G. Komen for the Cure Advocacy Alliance, the American Cancer Society, the Alzheimer's Foundation of American, and dozens of other national organizations.

Along with Senator HUTCHISON, this bipartisan amendment is also sponsored by Senators FRANKEN, WHITEHOUSE, SANDERS, SPECTER, and CARDIN. Please join us in supporting amendment No. 2871.

I yield the floor.

The PRESIDING OFFICER (Mr. KIRK). The Senator from Delaware is recognized.

Mr. KAUFMAN. Mr. President, I ask unanimous consent to speak as in morning business for up to 15 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

FINANCIAL MARKETS AND JOB LOSS

Mr. KAUFMAN. Mr. President, my colleagues have heard me speak in recent weeks about the troubling trends in our financial markets—the growing use of dark pools and high-frequency trading, increasing market fragmentation and looming regulatory gaps at the Securities and Exchange Commission. Today, I want to talk about an economic threat that encompasses these developments and why I think they are negatively affecting the long-term health of our economy.

After suffering through the most severe recession in decades, we are now in the midst of the most fragile of recoveries. It is evident to all that we are in a jobs crisis. We need a laser-like focus on innovation policies that encourage industry to create jobs. But this challenge comes not just from the financial crisis and the recession that followed, the American economy has slowed in its efforts to create jobs for the past decade.

According to the Bureau of Labor Statistics, the United States had 108.5 million private, nongovernmental jobs as of September of this year. But while our population has grown 9 percent in the last 9 years, the number of jobs now available is essentially the same as June of 1999.

Let me repeat that: The number of jobs now available is essentially the same as June of 1999—over 10 years ago.

Many of the jobs this economy did create in the past decade were in the financial, housing, and consumer-led retail sectors. Two of those—financial and housing—were bubbles that have now burst. Without these sectors playing a key role in providing new jobs, many Americans are asking: Where will the future job creation most likely occur?

In the past, job creation would often come from the raft of small, newly financed, often innovative companies that raised their capital with the help of Wall Street underwriters. Thousands of times I have heard in the last months that the recovery is going to come because of small businesses, and many of those raise their capital with the help of Wall Street underwriters.

Now I am deeply concerned there is a choke point in our efforts to return to economic vibrancy, a choke point that can be found on Wall Street. Our capital markets, which have long been the envy of the world, are no longer performing one of their most essential functions; that is, the constant and reliable channeling of capital through the public sale of company stock, known as initial public offerings—or IPOs—which small companies use to innovate and, most importantly, to create jobs.

Look at this chart. There is an IPO crisis in this country. Indeed, according to a report released last month by the accounting firm Grant Thornton, the IPO market in the United States has practically disappeared. That, in turn, according to a second Grant Thornton study, has had a ripple effect on the U.S. stock markets, with the number of stock listings since 1991 dropping 22 percent in absolute terms and 53 percent when factoring in inflation-adjusted GDP growth.

New companies have been shed from the NASDAQ, New York, and American Stock Exchanges faster than being created, from almost 7,000 publicly listed companies in 1991 and nearly 8,900 in 1997, during the dot-com bubble, to 5,400 listed in 2008, a turn of events Grant Thornton has dubbed the ''Great Depression of Listings.''

The United States is practically the only market in the world where this phenomenon is occurring. The major stock exchanges—as you can see from this chart—in Hong Kong, London, Milan, Tokyo, Toronto, Sydney, and Frankfurt, have all grown from their 1997 levels, Grant Thornton reports. Just look at this chart. This is what is going to take us out of the recession. Look at where we are—the United States—in relation to Hong Kong, Tokyo, Australia, and the other markets.

The effects of the IPO crisis have rippled throughout the U.S. economy. Because 92 percent of job growth occurs after a company goes public, job creation may have been stunted by these developments. In fact, according to the Grant Thornton study, if the IPO market was working properly today, we would have as many as 10 million to 20 million additional high-quality jobs for middle-class Americans. Even if that estimate is off by a factor of 10, this failure of Wall Street to provide capital to small companies may be costing our economy millions of jobs.

Mr. President, most every large company begins as a small company. That is axiomatic. The IPO market has been hit hardest at the smallest end of the market. The medium IPO in the first 6 months of 2009 was $135 million. Let me say that again—$135 million. Twenty years ago, IPOs at $10 million were routine, and routinely succeeded.

Take a look at this chart and look at these companies. Venture capitalists play a critical role in long-term investment, in growing our economy and creating jobs. Indeed, when you look at these 17 venture-backed companies that raised a total of $367 million in capital and today provide 470,000 U.S. jobs, they are among our economy's biggest success stories.

Look at this list. Think of where we would be today if these companies were not able to get IPS: Adobe, Computer Associates, Intel, Oracle, Yahoo. These are all the companies where growth came from. Right now, in our present market, they cannot go public the way they went public originally.

What has happened? A host of well-intentioned changes—some technological, some regulatory—with many unintended consequences have created this situation. Online brokerage firms, with their $25 trades, first appeared in 1996, hastening the decline of traditional full-service brokerage firms who charge $250 a trade. There was an advantage to those hefty fees, however. They helped maintain an underwriting apparatus that encouraged small businesses to go public and supported a substantial research base that attracted both institutional and retail clients.

The rich ecosystem of investment firms, including the Four Horsemen—Robertson Stephens, Alex Brown & Sons, Hambrecht & Quist, and Montgomery Securities—that helped their institutional buy-side clients take part in IPOs and marketed follow-on offerings, no longer exists today.

Structural changes in the U.S. capital markets dealt the final coup de grace. There were new order handling rules—decimalization, which shrank spreads significantly and made it increasingly difficult for traditional retail brokers to remain profitable; Regulation ATS and NMS, which vastly expanded the electronic marketplace.

Finally, there has been an explosive growth in high-frequency trading, which takes advantage of the market's now highly automated format to send more than 1,000 trades a second ricocheting from computer to computer.

The result, as The Economist magazine wrote last week, is that high-frequency traders who have come to dominate stock markets within their computer-driven strategies pay less attention to small firms, preferring to jump in and out of larger, more liquid shares.

The economist quoted:

> Institutional investors wary of being stuck in an illiquid of the market are increasingly following them.

This is a situation that stands as a veritable wall against a sustained economic recovery.

One of the very vital tasks before Congress is to help unemployed Americans by crafting innovation policies that will rebuild our economy, catalyze growth, and create high-quality jobs for struggling Americans. That is our No. 1 job in the Congress right now. I think if you asked every 1 of the 100 Senators, they would say that is the case.

We must identify the causes of last year's debacle and apply them to our current economic challenges in order to help the millions of struggling Americans and to avert a future disaster. The fact that Wall Street has resumed its risky and—as we know all too well—potentially disastrous behavior is simply inexcusable.

In order to reverse this ominous trend and help companies raise capital to innovate, create jobs, and grow, we must restore the financial sector's historical role as a facilitator of long-term growth and not the source of one bubble after another.

The question, finally, is this: How can we create a market structure that works for a $25 million initial public offering, both in the offering and the secondary aftermarket? If we can answer that question, this country will be back in business.

Mr. President, I yield the floor, and I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. KAUFMAN. Mr. President, I ask unanimous consent the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. KAUFMAN. Mr. President, I ask to speak as in morning business for up to 5 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

IN PRAISE OF WILLIAM PHILLIPS

Mr. KAUFMAN. I rise once again to recognize one of America's great federal employees.

Last week, in Stockholm and Oslo, the 2009 Nobel laureates accepted their prizes. I am particularly proud that 11 of this year's 13 prizes were won by Americans. This is a reminder of our Nation's global leadership in science, medicine, economics, and peacemaking.

My honoree today holds the distinction of having been the first Federal employee to win a Nobel Prize in physics for work performed while serving the public.

Our Federal workforce is composed of citizens who are both highly educated and incredibly motivated.

Dr. William Phillips is the perfect example. A native Pennsylvanian, William learned the importance of public service and hard work from a young age. His mother, an immigrant from Italy, and his father, a descendent of American revolutionaries, were the first in their families to attend college. They both pursued careers as social workers in Pennsylvania's coal-mining region. William, along with his brother and sister, grew up in a home where reading and education were emphasized.

As a boy, William fell in love with science, and he tinkered with model rockets and chemical compounds in the basement of his family's home. While attending Juniata College in the 1960s, William delved into physics research. He spent a semester at Argonne National Laboratory and, after graduation, pursued his doctorate at M.I.T.

During his time at M.I.T., the field of laser-cooling was just heating up, and William wrote his thesis on the collisions of atoms using this new technology.

In 1978, William began working at what is today the National Institute for Standards and Technology—or ''NIST''—at the Department of Commerce. At NIST, he pursued further research into laser-cooling, and his discoveries have helped open up a new field of atomic research and expand our knowledge of physics. His findings have found important application in precision time-keeping, which is important for both private industry and for national security.

In 1997, William received the Nobel Prize for Physics along with two other scientists. One of his fellow-laureates that year was Dr. Steven Chu, who now serves as Secretary of Energy.

After winning his Nobel Prize, William made a commitment to using his fame to promote both science education and public service. He regularly speaks to student groups, and he serves as a mentor to graduate students in his field.

William won the prestigious Arthur S. Flemming Award for Public Service in 1987, and he was honored by the Partnership for Public Service with its 2006 Service to America Medal for Career Achievement.

He and his wife, Jane, live in Gaithersburg, MD, and are active in their community and church. Today, after a 3-decade Federal career, William continues to work at NIST as the leader of its Laser-Cooling and Trapping Group.

I hope my colleagues will join me in honoring Dr. William Phillips and all those who work at the National Institute of Standards and Technology for their dedicated service and important contribution to our national life. They keep us at the forefront of science and human discovery. They do us all proud.

I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. MCCAIN. Mr. President, I ask unanimous consent the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. MCCAIN. Mr. President, before my colleagues begin, I think it is important for us to point out where we are here on December 16, 2009. We are now almost a year into the discussion and debate about ''reforming health care in America'' and we still do not know what is in the bill. We still do not know the specifics of what we are considering here.

I have had the honor of serving here for a long period of time, but I have never seen a process like this. I have never seen a situation where a major piece of legislation is not before the body and is somehow being negotiated and renegotiated amongst the other side. Meanwhile, according to the Washington Post this morning, a newspaper I always have the utmost trust and confidence in—I wish to say the title is ''Public cooling to health-care reform as debate drags on, poll finds.''

As the Senate struggles to meet a self-imposed, year-end deadline to complete work on legislation to overhaul the nation's health-care system, a new Washington Post-ABC News poll finds the public generally fearful that a revamped system would bring higher costs while worsening the quality of their care.

A remarkable commentary about where we are in this legislation. One of the interesting things is this poll goes back to April, where in April, 57 percent of the American people approved and 29 disapproved of the President's handling of health care. Today it is 53 disapprove and 44 approve, which means the American people, the more they find out about this, the less they like it and the more concerned they are. According to this poll again:

Medicare is the Government health insurance program for people 65 and older. Do you think health-care reform would strengthen the Medicare program, weaken Medicare or have no effect on it?

American people have figured it out. Amongst seniors, those who are in Medicare, 12 percent say it would strengthen, 22 percent no effect, and 57 percent of seniors in America believe—and they are correct—that this proposal would weaken Medicare, the benefit they paid into and that they have earned.

Let me say it again: I plead with my colleagues on the other side of the aisle and the majority leader. Let's stop this. The American people do not approve of it. Let's sit down and work together; let's have real negotiations; let's even have the C–SPAN cameras in, as the President promised October a year ago. This present legislation spends too much, taxes too much, and reduces benefits for American citizens as far as overall health care is concerned, including Medicare, as the American people have figured out.

I welcome my colleagues here. I see Dr. COBURN is here. Let me restate: It is time to say stop. It is time to start listening to the American people. It is time to start being straightforward with the American people because the American people need to know what we are doing and they do not. The distinguished Senator from Illinois, last Friday when I asked him what is in the bill, said none of us know what is in the bill.

I ask my friend from Oklahoma, isn't what is happening—we have a proposal, we send it to CBO, CBO sends back numbers they do not like so they try to fix it, send it back to CBO, they send it back again. That is why only one Senator, the majority leader, knows what is going on.

Mrs. HUTCHISON. Mr. President, parliamentary inquiry.

Mr. MCCAIN. What is the parliamentary situation, I ask the President?

Mrs. HUTCHISON. Mr. President, I was under the impression there would be a 30-minute allocation for colloquy for our side. I am not sure when we start that process.

The PRESIDING OFFICER. The Republican side has 25 minutes 15 seconds.

Mrs. HUTCHISON. How many?

The PRESIDING OFFICER. There is 25 minutes 15 seconds.

Mr. MCCAIN. Mr. President, I thank the Chair. I think I have made my point here. I wish to yield. I ask unanimous consent to have a colloquy with the Senator from South Dakota, the Senator from Texas, the Senator from Oklahoma, and the Senator from Wyoming.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. COBURN. If I might respond to the question of the Senator, one of the things our President has promised is transparency. We are going to see at sometime in the next week or 10 days another bill—whatever the deal is. It would seem to me that 72 hours with a complete CBO score, much like was asked by 12 Members on their side, before we have to take up or make any maneuvers on that, would be something everybody could agree to since nobody knows, except HARRY REID and the CBO, what is in this bill now. At a later time, after we finish this colloquy, I will be making that unanimous consent request.

Mrs. HUTCHISON. I thank the Senator from Oklahoma. I think it is very important that before we start talking about passing a bill or having a cloture on a bill—I think the Senator from Oklahoma is making the main point. I think the Senator from Oklahoma was making a very good point that I was hoping to work with him on and that is: Where are we now? The Republicans have put forward reform alternatives for our health care system that are not a government takeover and are not going to be $½ trillion in taxes and are not going to be $½ trillion in Medicare cuts.

The Republican proposals would do what health care reform should do—they would lower cost. They would increase risk pools so that small business would be able to offer health care coverage for their employees. They would have medical malpractice reform so we would be able to lower the cost of frivolous lawsuits, cutting over $50 billion out of the costs of health care, making it more accessible for more people. They would give tax credits for individuals who would buy their own health care coverage to offset that cost.

None of that would be a big government takeover of health care. That is what we have been trying to put forward here. But we have not had a seat at the table. We have not had the capability to say what our proposals would be because we have not even seen the proposed new bill yet. We have been talking about the tax increases that are going to burden small business at a very hard time for this country's economy and we have also been talking about $½ trillion in Medicare cuts, which I think has caused many senior citizens to say: Wait a minute, I don't want my Medicare options cut. I don't want Medicare Advantage to be virtually taken away.

That is why we are here today, because the pending business before the Senate is the Hutchison-Thune motion to recommit this bill to do a simple thing. It is to say that you will not start collecting the taxes until the program is in place. It is very simple. It is the American sense of fair play, and that is that you do not start collecting taxes before you have a program that you might want to buy into. That is what the Hutchison-Thune motion to recommit does. It is very simple. It is a matter of fair play. I even question whether we have the right to pass taxes for 4 years before you would ever see a program put in place.

We are going to try to do what is right by this body. That is to say, the $100 billion in new taxes that will start next month—3 weeks from now—will not start until there is a program put in place. Because right now $100 billion in new taxes starts next month but there is no program that anyone can sign up for that will supposedly make it easier to get health care coverage in this country until 2014, 4 years away.

I ask my colleague, the distinguished ranking member of the Finance Committee, if he believes all these new taxes would be fair to start before we could ever see a program—not 1 year from now, not 2, not 3 but 4 years from now. I ask the distinguished ranking member of the Finance Committee if he believes it would be fair for us to start the taxes in 3 weeks and then not start the program for 4 years. Does that seem like a fair concept?

The PRESIDING OFFICER (Mr. CASEY). The Senator from Iowa.

Mr. GRASSLEY. Mr. President, the Senator is absolutely right. Let me emphasize it this way. I was on a radio program in Iowa yesterday, where a lady called me, and I had been saying, as the Senator has just said, that you have to wait until 2014 for this program to go into effect. She said: You are telling me you are going to pass this bill right now, but we have to wait until 2014 until we get any benefit from it? She didn't talk about the taxes, as the

Senator is, but the taxes go into effect. Another smokescreen is, you have 10 years of tax increases, fee increases, and the program is 6 years long, but the taxes are 10 years long. So it is nice for the CBO to say: Yes, this is balanced and maybe even has a surplus in it. But over the long term, this program does not cost just $848 billion. I hope I answered your question.

Mrs. HUTCHISON. You did. It is interesting because you say maybe it is going to be break even. How is it going to break even? I ask my colleague from South Dakota, who is a cosponsor of this motion: How is it going to break even? With $½ trillion in Medicare cuts, $½ trillion in tax increases, is that the way we ought to be saying to the American people we will reform health care? Have we lost the purpose of the bill, to make health care more affordable and accessible to the American people? I ask my colleague, the Senator from South Dakota, who has worked on this issue for a long time, is that the concept of break even?

Mr. THUNE. The Senator from Texas has touched on a very important issue. The motion she offers, and which I cosponsor, does lay out what is a simple principle of fairness that most Americans understand. When you implement public policy, if you are going to raise taxes, you ought to align the tax increases and the benefits so they start at essentially the same time. What this bill does is it starts collecting taxes, increases taxes on Americans 4 years before the major benefit provisions kick in. On January 1 of 2014, 99 percent of the spending under the bill kicks in. But the tax increases begin less than 3 weeks from today. Sixteen days from now is when the tax increases in the bill start. A tax on prescription drugs, a tax on medical devices, a tax on health plans—all begin 16 days from now. A lot of those taxes will be imposed upon the American economy and passed on to people and small businesses in the form of higher premiums. People are going to get higher premiums 4 years before they are likely to see any benefit. Ninety-nine percent of the spending under the bill doesn't kick in until January 1, 2014, or 1,477 days from now. Most Americans, as they listen to the debate, believe as I do, as a simple principle of fairness, you ought to align the benefits and the taxes. We had a vote yesterday on the Crapo motion that would recommit all the tax increases. Many of us believe raising taxes on small businesses when you have an economy in recession is not a smart thing to do; it is going to cost us a lot of jobs. Small businesses have made that clear. I also think, in addition to the principle of fairness that is at play, when it comes to raising taxes 4 years prior to the benefits kicking in, you also need to have a transparent sort of understanding about what the cost of the bill is going to be.

One of the reasons the revenue increases, the tax increases were begun immediately or 16 days from now, but the majority of the spending, 99 percent, doesn't occur until January 1 of 2014 and beyond is to understate the true cost. They wanted to bring the cost of the bill in under $1 trillion.

If you can see, starting this year and going through 2019, it ends up at about $1 trillion or $1.2 trillion on this chart. But if you look at the fully implemented period; that is, 2014, when the benefits and spending begin, and take that through the next 10 years, the total spending in the bill is $2.5 trillion over a 10-year period.

That is one thing the American people need to know. One of the reasons this is being done, tax increases starting January 1 next year or 16 days from now, most of the benefits not starting until 1,477 days from now, is so they can say this is only a $1 trillion bill or under $1 trillion, the way it has been advertised, when, in fact, it is going to cost $2.5 trillion when fully implemented.

We are here 16 days before the Christmas holiday, and there are things Congress needs to do. There are a number of fairly urgent matters that need to be dealt with before the end of the year, some of which have been mentioned this morning. But trying to jam through a new health care program, a $2.5 trillion expansion of the Federal Government in Washington, 70 new government programs, trying to jam it through in the next 9 days or so before Christmas seems to be done more out of a political necessity, the need for a political accomplishment or a political victory, than it does with making good public policy. As the American people are approaching this holiday season, the best thing we can do, the best Christmas gift we could give the people, frankly, is for Congress to adjourn and go home before passing this $2.5 trillion expansion.

What does it mean? If you are a small businessperson, the Christmas gift you get this year is a big lump of coal from the Congress in the form of higher taxes. If you are a senior citizen, 1 of the 11 million who are on Medicare Advantage and this bill passes, your Christmas gift this year is benefit cuts. The same thing applies to many of our providers—hospitals, nursing homes, home health agencies, hospices. If you are an average American family who is worried about the high cost of health care, your Christmas gift this year is, if this bill passes, that your health insurance premiums will continue to go up year over year at twice the rate of inflation. You lock in higher premiums for most people across the country, you raise taxes on small businesses, you cut benefits to Medicare beneficiaries and, for future generations, you create a $2.5 trillion new entitlement program they will be paying for, for as far as the eye can see.

The CMS Actuary, last week, said, in addition to all the other things they mentioned—the overall cost of health care is going to go up, 20 percent of hospitals will close—that the Medicare cuts that are being proposed cannot be sustained on a permanent basis. If that is true, how will this be financed? Either with more taxes or borrowing, putting it on the debt and handing the bill to future generations. That is what we are left with. Once you lock in a $2.5 trillion expansion of the Federal Government, it is going to be hard to reduce the cost. The spending is not going to go away. The way it will be paid for, if the Medicare cuts are not sustainable, is the tax increases. The increases that are already in here would have to be increased even further or, worse yet, for future generations, if you are a young American, it will be put on your bill.

The Senator from Texas and my colleagues who are here this morning all voted yesterday to get rid of the tax increases in the bill. But the motion she offers and that I cosponsor would at least, as a principle of fairness, make sure those tax increases don't begin before the benefits do.

Mrs. HUTCHISON. Mr. President, the 2 physicians out of the 100 Members of Senate are here this morning. They have talked for a long time about the quality of care. They are the two who have the credibility on this. I would like to ask the Senator from Wyoming, Dr. BARRASSO, to talk about what is going to happen to the quality of health care when you have $½ trillion in Medicare cuts, which we have discussed, and the bill we are discussing today and the motion Senator THUNE and I are offering, that is going to put a higher cost on every prescription drug, every piece of medical equipment. Perhaps you would expand on what kind of medical equipment is needed for people to have the quality of life we have in our country today and then the insurance companies, which are, of course, going to raise the premium of every person who already has coverage.

I ask the Senator from Wyoming, Dr. BARRASSO, in your experience, how is this going to affect the quality of health care?

Mr. BARRASSO. I am grateful to the Senator for bringing this up. I had a telephone townhall meeting last night, and this specific motion the Senator is bringing today came up with great praise from the people of Wyoming who said: She is doing it right, leading the good fight. After I answer the question, I will ask: How do we know the money is even going to be there? That is the question that came up in my telephone townhall. People of Wyoming are concerned, if this passes, it will make health care harder for people in rural States, such as Wyoming and Montana. My colleague from Montana is on the floor. The doctor shortage will worsen. This is the headline on the front page by the Wyoming Tribune Eagle: ''Doctor Shortage Will Worsen.'' There is a lot of concern for the folks in Wyoming and communities where there is a sole

hospital, a sole physician provider trying to recruit nurses and physician assistants and nurse practitioners. The doctor shortage will worsen as we see a situation where they will be cutting Medicare $500 billion, raising taxes $500 billion, and people who had insurance on this telephone townhall were very concerned that their insurance premiums are going to go up, in spite of the fact that the President has promised families would see insurance rates go down. We know those rates are going to go way up for people who buy their own insurance. People say: Don't cut Medicare, don't raise taxes, don't make matters worse than they are right now. For the people of Wyoming, they are afraid that matters will be made worse.

The Washington Post had a major poll in the paper today specifically asking seniors the question about Medicare. We are talking about health care quality, the quality of care. The question is: Do you think health care reform will strengthen the Medicare Program or weaken the Medicare Program? They asked specifically and broke it down to seniors. Only 1 out of 8 seniors in this poll said it actually would get better. But the rest are saying: No, it is going to get worse. The seniors who watch this most carefully know what it means to try to get health care under the Medicare Program, a program that we know is going broke. Yet they are taking all this money not to save Medicare but to start a new program. We know the quality of care is going to go down. That is what the people of my home State and the people I talked to from around the country are concerned about. They are delighted the Senator offered this motion.

I did a poll in the townhall meeting: Are you for or against the bill? Some of them say: What is in it? We don't know. Which is exactly what the junior Senator, a Democrat from Indiana, said in today's national press release: We are all being urged to vote for something, and we don't know the details of what is in it. The junior Senator from Indiana is a Democrat. He doesn't know what is in it. The people of Wyoming don't know what is in it. But they do know taxes start immediately, benefits not for 4 years. That is why they are happy you offered this motion. They want to know: How do we know the money will be there 4 years from now?

Mrs. HUTCHISON. That is a very important question. Here we are going to start collecting the taxes for 4 years before the program is put in place. The distinguished Senator from Oklahoma, the other physician in this body, knows we have had promises from the Federal Government before. But I can't remember a time when we started collecting a tax for a purpose that would be 4 years away. What on Earth could people expect to actually be there when the program kicks in?

The program is going to have to be implemented. It is going to have to be brought up to speed. I am sure there will be changes. What would you think your patients whom you still care for in Oklahoma or the ones, in the experience you have had, how do you think people are going to react to having higher costs in all these areas of health care for 4 years, even a tax on the high-income plans, not high-income people having those plans but high coverage that a union member might have that will start being taxed in 2013, 1 year before the program takes effect?

How do you think that is going to affect the quality of health care people can expect and the cost to them out-of-pocket when there would be nothing even on the drawing boards for 4 years?

Mr. COBURN. To answer the Senator's question, No. 1, as we already know, the Oklahoma State employees' health insurance plan, in 2013, will be considered a Cadillac plan. That is every State worker in the State of Oklahoma. And they can hardly afford their copays and their premiums in that plan today. So what we know is, we are going to tax all the Oklahoma workers. Many of those are schoolteachers who happen to be my patients, and they are struggling today.

So this disconnect between when the taxes are——

Mrs. HUTCHISON. I ask the Senator from Oklahoma, you are saying that a schoolteacher is probably not making $200,000 or more?

Mr. COBURN. Not at all.

Mrs. HUTCHISON. Yet we were promised there would be no taxes, no harm to people making under $200,000. Remind me if there is a teacher in Oklahoma—because I know there is not one in Texas—making over $200,000.

Mr. COBURN. Well, our teachers wish they made what the teachers in Texas make, but they do not. But they do not make anywhere close to $200,000. It does not just affect the Department of Human Services workers, it is also going to impact the premium increases that are going to come about before this plan is implemented. We are going to see premium increases. So the small businesses that are now covering people are going to have massive premium increases. The individuals who are buying insurance in the open individual market themselves are going to see premium increases. The fact is, that is all going to happen before the first benefit, the first real benefit—other than preexisting illnesses—before anybody sees any benefit to that.

The other thing that is not talked about is, with the skewing of this and with the relatively low tax on not complying with it, our youngest, healthiest people are going to say: I don't want any insurance because all I have to do is pay, in the first year, $250—or even less—up to $750, and I can save thousands of dollars every year by not buying insurance, and buying it when I get sick.

So we are going to see everything skewed in the insurance market. That is what is going to drive up the premiums.

My constituents, plus my patients, are not happy about the delay. If we are going to make this, what I believe, is a fatal mistake for our country in terms of the quality of health care, then we ought to at least match the revenues with the expenses.

Mrs. HUTCHISON. That is exactly what the Senator from South Dakota and I are trying to do. We are trying to make sure Americans will not—will not—pay taxes and increased prices on prescription drugs, on coverage we do have, the policies we do have, and the equipment that is so necessary for health care services.

Senator THUNE and I want to do what is basic fairness and very simple; that is, to say the program starts and the taxes start at the same time. That is a tradition we have had in this country for years. We do not tax people 4 years from having any kind of program in place that they could choose from that might benefit them. We do not do that. That is not the American way, and it is certainly not anything we have done before.

What in the world would people expect to happen in 4 years? What if this plan is changed? What if the people rise up and say: We don't want this plan, and they say: No way, and they would have been paying higher premiums and higher health care costs already. It is a downpayment where you are not sure what the end is going to be.

It is like buying a house and saying: Now, in 4 years we are going to give you the key to the house, we are going to give you the key to the house that you bought 4 years from now. Oh, maybe there will be a change in condition, but you are going to get it. Maybe it will be damaged. Maybe it will be worn. Maybe it will have a fire that starts in part of it. But you will get those keys and then something will be there for you. We promise you. We are from the government, and we are going to promise you that.

That is not good enough. That is not what we owe the American people. And it is not health care reform.

I would just ask my colleague from South Dakota, who is the cosponsor of this motion, if he agrees that as a matter of simple fairness, openness, and transparency to the American people, health care reform should not mean 4 years of taxes before any program is put in place.

Mr. THUNE. I will say to my colleague from Texas, as to the taxes, the fees, the tax increases, everything in our motion very simply states they ought to be aligned with the beginning of the benefits. The benefits and the exchanges and, frankly, all the major policies—the substance of this bill—begin in 2014; the individual mandate, the State exchanges, the subsidies, as I said, premium tax credits, Medicaid expansion, the employer mandate, 2014; the government plan, 2014. The substance of this bill begins in 2014. Unfortunately, the tax increases begin 4 years earlier, 16 days from now. Sixteen days from now, January 1 of this

coming year, is when the taxes start being raised. And, of course, the CBO has said those tax increases are going to be passed on in the form of higher premiums to people across this country. The benefits start 1,477 days from now.

So what we simply say in this motion is, let's commit this bill and bring it back out with the tax increases—if there are going to be tax increases; and many of us believe there should not be any, which is why we voted for the Crapo motion yesterday—but if you are going to raise taxes on America's small businesses, families, and individuals, at least align those so the policy, the substance of this bill, which begins 4 years from now, is synchronized so we are not slapping a huge new tax increase on America's small businesses in the middle of a recession and passing on those higher costs, which is what they will do, to people in this country in the form of higher insurance premiums.

So I say to the Senator from Texas, this is a very straightforward, simple motion. I hope our colleagues on both sides will support it. It is a matter of principle, of fairness when its comes to making policy that I think the American people have come to expect. We ought to be honest and give the American people a complete understanding of what this bill really costs. Because they have done what they have done—by instituting the tax increases immediately and the spending 4 years from now—it understates the overall cost of this legislation. The American people need to know this is a $2.5 trillion bill when it is fully implemented. The only reason they can bring that in under that number is because they start raising taxes immediately and do not start paying benefits out for another 4 years.

So I say to the Senator from Texas, I hope when we get to this vote, it will be a big bipartisan vote in the Senate, and I hope we will make a change in this legislation that implements some semblance of fairness and also gives us a true reflection of what the bill really costs.

Mrs. HUTCHISON. I thank the Senator from South Dakota.

Just to recap, the amount that would actually be collected before any program is put in place would be $73 billion—already collected. That will include, as the Senator from Oklahoma mentioned, schoolteachers from Oklahoma who are considered to have these high-benefit plans, a schoolteacher making $50,000, $60,000 a year with a high-benefit plan. And do you know what the tax is on that high-benefit plan? Do you know what the tax is on that Oklahoma schoolteacher? A 40-percent excise tax—40 percent.

The PRESIDING OFFICER. The Senator's time has expired.

Mrs. HUTCHISON. Mr. President, I thank the Senator, and I would just say I hope we get a bipartisan vote on this motion. I hope we get a bipartisan vote to say the one thing we ought to do, if nothing else, is be fair to the American people. You do not pay taxes until the program is up and going.

Thank you, Mr. President.

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. COBURN. Mr. President, I ask unanimous consent to offer some unanimous consent requests to the chairman of the Finance Committee.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. COBURN. Mr. President, I offer a unanimous consent request that it not be in order for the duration of the consideration of H.R. 3590 to offer an amendment that has not been filed at the desk for 72 hours and for which there has not been a complete CBO score.

The PRESIDING OFFICER. Is there objection?

The Senator from Montana.

Mr. BAUCUS. Mr. President, reserving the right to object, I would like to just remind our colleagues, I have sought it, and I think it has been basically a very forthright, open process we have conducted here. Certainly in the Finance Committee—I see my colleague from Iowa on the floor—it was totally transparent for months upon months, with hearing upon hearing. We posted amendments in the Finance Committee on the Internet in advance of consideration.

I have never been part of a more transparent process since I have been here, frankly, at least for something of this magnitude over this period of time. In fact, one reporter even said to me: Senator, is this the new way we do things around here? It is so transparent, so bipartisan, and so forth. I said: I don't know. I sure like it that way.

I also remind all of us that Senator REID's amendment was made available on November 18 of this year, and 3 days later, on the 21st, we voted for cloture on the motion to proceed. Then, 12 days after the Reid amendment was made available, we finally began debate on the bill. And here we are, nearly a month later. So this bill has been out here.

The Senator mentioned, I note, having in mind the managers' amendment, which he has not seen and, frankly, this Senator has not seen either. I have some ideas what is in it, but I have not seen it myself.

I think as a practical matter this will be available for 72 hours, as the Senator suggests. Why do I say that? I say that because it is my expectation that Senator REID's managers' amendment will be filed very quickly, maybe in a day or two. It is also my expectation that we will then proceed, according to expectations here, to the Defense appropriations conference report, which we will then be working on for several days. And probably a cloture motion might be filed on the health care bill—on the managers' amendment probably not until after we do Defense appropriations. So during the interim, everyone is going to be able to see, at least for more than 72 hours, the contents of the managers' amendment in the health care bill which Senator REID is going to be filing. So as a practical matter, I think it is going to happen.

I cannot at this point agree to the request to lock that in for 72 hours, but I think as a practical——

Mr. COBURN. Will the Senator yield for a question?

Mr. BAUCUS. Yes.

Mr. COBURN. One of the reasons I want this, is it not his belief that the American people ought to get to see this for 72 hours as well and that it ought to be on the Internet and that everybody in America, if we are going to take one-sixth of our economy, ought to have the time to truly read—we are going to have a managers' amendment, and that is actually what mine is focused on.

Mr. BAUCUS. Sure.

Mr. COBURN. But to be able to truly not just read the managers' amendment but then go into the bill where it is going to fix the bill.

Mr. BAUCUS. I think that is a good idea. I think it is going to happen.

Mr. COBURN. But the Senator will not agree to it by unanimous consent?

Mr. BAUCUS. I cannot at this time but, again, saying it is my expectation it will be available for more than 72 hours.

Mr. COBURN. I appreciate the sincerity of the chairman's remarks.

Mr. BAUCUS. I thank the Senator. I object.

The PRESIDING OFFICER. Objection is heard.

Mr. COBURN. Mr. President, I have another unanimous consent request. The following consent request would be associated with a Coburn amendment that would certify that every Member of the Senate has read the bill and understands it before they vote on the bill. The reason I ask unanimous consent that amendment be agreed to and accepted is that is exactly what the American people expect us to be doing.

So we do not have a bill right now. We do not know what is going to be in the bill. The chairman has a good idea what is going to be in the bill, but he does not know for sure. Only two sets of people—Senator REID and his staff and CBO—know what is going to be in the bill. I suspect somebody at the White House might.

But we ought to take and embrace the idea of transparency and responsibility, that the American people can expect every one of us to have read this bill, plus the amended bill, and certify that we have an understanding for what we are doing to health care in America with this bill.

I ask unanimous consent that be accepted.

The PRESIDING OFFICER. Is there objection?

The Senator from Montana.

Mr. BAUCUS. Mr. President, reserving the right to object, I certainly agree with the basic underlying import that we should know what we are voting on here. But I must say to my good

friend from Oklahoma, I cannot certify that Members of the Senate will understand what they are reading. That presumes a certain level of perception on my part in understanding and delving into the minds of Senators that not only have they read but they have taken the time to understand. And what does ''understand'' mean? Understand the second and third levels, the fourth level of questions? I think it is a practical impossibility for anybody to certify that any other Senator has fully understood. They may read, but they may not fully understand for a whole variety of reasons. So I cannot certify that.

Mr. COBURN. Could I clarify my request?

Mr. BAUCUS. I have to object.

The PRESIDING OFFICER. Objection is heard.

Mr. COBURN. Let me clarify my request that the individual certify themselves. I am not asking some group of Senators to certify some other Senator. I am saying that Tom Coburn tells his constituency: I have read this puppy. I have spent the time on it. I have read the managers' amendment, and I, in fact, certify to the people of Oklahoma that I know how terrible it is going to be for their health care.

Mr. BAUCUS. The Senator is always free to make any representations he wants. If he wants to certify he has read it and certify that he has understood it, that is the Senator's privilege.

Mr. COBURN. But the Senator won't accept that we as a body, on one-sixth of the economy, ought to say we know what we are doing?

Mr. BAUCUS. I can't certify that every Member of the Senate has done anything around here. Neither can the Senator from Oklahoma. That is an impossibility. But if the Senator wants to certify he has read it, that is great, and understands it fully, that is great, on any measure—not just this measure but any measure. But I can't certify that for 100 different Senators, on any measure. That is up to the individual Senators and that is up to their mental capacities and up to their initiatives and imaginations and conscientiousness and so forth. I can't certify to that.

Mr. COBURN. I thank the chairman.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Senator from Vermont be recognized to proceed for at least a half hour.

The PRESIDING OFFICER. The Senator from Vermont is recognized.

AMENDMENT NO. 2837 TO AMENDMENT NO. 2786

Mr. SANDERS. Madam President, I call up my amendment per the order.

The PRESIDING OFFICER (Mrs. HAGAN). The clerk will report the amendment.

The assistant legislative clerk read as follows:

The Senator from Vermont [Mr. SANDERS], for himself, Mr. BURRIS, and Mr. BROWN, proposes an amendment numbered 2837 to amendment No. 2786.

Mr. SANDERS. Madam President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Is there objection?

Mr. COBURN. Madam President, I object.

The PRESIDING OFFICER. Objection is heard.

The assistant legislative clerk continued with the reading of the amendment.

Mr. SANDERS. Madam President, I ask unanimous consent that the amendment be considered as read.

The PRESIDING OFFICER. Is there objection?

Mr. COBURN. There is objection.

The PRESIDING OFFICER. Objection is heard.

Mr. SANDERS. Madam President, may I ask my friend from Oklahoma why he is objecting?

Mr. COBURN. Regular order, Madam President.

The PRESIDING OFFICER. Regular order is the reading of the amendment.

The assistant legislative clerk continued with the reading of the amendment.

(The amendment (No. 2837) is printed in the RECORD of Wednesday, December 2, 2009, under ''Text of Amendments.'')

The PRESIDING OFFICER (Mr. CARDIN). The Senator from Vermont is recognized.

AMENDMENT NO. 2837 WITHDRAWN

Mr. SANDERS. Mr. President, I withdraw my amendment.

Mr. COBURN. Regular order, Mr. President.

The PRESIDING OFFICER. The Senator has that right. The amendment is withdrawn.

Mr. SANDERS. Pursuant to the 30 minutes that I——

The PRESIDING OFFICER (Mrs. SHAHEEN). Under the previous order, the Senator from Vermont is recognized for 30 minutes.

Mr. SANDERS. Madam President, let me begin not by talking about my amendment but by talking about the Republican action that we have seen right here on the floor of the Senate. Everybody in this country understands that our Nation faces a significant number of major crises—whether it is the disintegration of our health care system, the fact that 17 percent of our people are unemployed or underemployed, or the fact that one out of four of our children is living on food stamps. We have two wars, we have global warming, we have a $12 trillion national debt, and the best the Republicans can do is try to bring the U.S. Government to a halt by forcing a reading of a 700-page amendment. That is an outrage. People can have honest disagreements, but in this moment of crisis it is wrong to bring the U.S. Government to a halt.

I am very disturbed that I am unable to bring the amendment that I wanted to bring to the floor of the Senate. I thank Senator REID for allowing me to try to bring it up before it was obstructed and delayed and prevented by the Republican leadership. My amendment, which was cosponsored by Senators SHERROD BROWN and ROLAND BURRIS, would have instituted a Medicare-for-all single-payer program. I was more than aware and very proud that, were it not for the Republican's obstructionist tactics, this would have been the first time in American history that a Medicare-for-all single-payer bill was brought to a vote before the floor of the Senate. I was more than aware that this amendment would not win. I knew that. But I am absolutely convinced that this legislation or legislation like it will eventually become the law of the land.

The reason for my optimism that a Medicare-for-all single-payer bill will eventually prevail is that this type of system is and will be the only mechanism we have to provide comprehensive high-quality health care to all of our people in a cost-effective way. It is the only approach that eliminates the hundreds of billions of dollars in waste, administrative costs, bureaucracy, and profiteering by the private insurance companies, and we are not going to provide comprehensive, universal, cost-effective health care to all of our people without eliminating that waste. That is the simple truth.

The day will come, although I recognize it is not today, when the Congress will have the courage to stand up to the private insurance companies and the drug companies and the medical equipment suppliers and all of those who profit and make billions of dollars every single year off of human sickness. On that day, when it comes—and it will come—the U.S. Congress will finally proclaim that health care is a right of all people and not just a privilege. And that day will come, as surely as I stand here today.

There are those who think that Medicare-for-all is some kind of a fringe idea—that there are just a few leftwing folks out there who think this is the way to go. But let me assure you that this is absolutely not the case. The single-payer concept has widespread support from diverse groups from diverse regions throughout the United States. In fact, in a 2007 AP/Yahoo poll, 65 percent of respondents said that the United States should adopt a universal health insurance program in which everyone is covered under a program like Medicare that is run by the Government and financed by taxpayers.

There is also widespread support for a Medicare-for-all approach among those people who understand this issue the most, and that is the medical community. That support goes well beyond the 17,000 doctors in the Physicians for National Health Care Program, who are fighting every day for a single-payer system. It goes beyond the California Nurses Association, the largest nurses union in the country, who are also fighting for a Medicare-for-all, single-payer health care. In March of 2008,

a survey of 2,000 American doctors published in the Annals of Internal Medicine concluded that 59 percent of physicians ''supported legislation to establish national health insurance.''

Madam President, you might be particularly interested to know that the New Hampshire Medical Society surveyed New Hampshire physicians and found that two-thirds of New Hampshire physicians, including 81 percent of primary care clinicians, indicated that they would favor a simplified payer system in which public funds, collected through taxes, were used to pay directly for services to meet the basic health care needs of all citizens. That is New Hampshire.

In 2007, Minnesota Medicine Magazine surveyed Minnesota physicians and found that 64 percent favored a single-payer system; 86 percent of physicians also agreed that it is the responsibility of society, through the Government, to ensure that everyone has access to good medical care.

But it is not just doctors, it is not just nurses, it is not just millions of ordinary Americans. What we are seeing now is that national, State, and local organizations representing a wide variety of interests and regions support single payer. These include the U.S. Conference of Mayors, the American Medical Students Association, the AFL/CIO, the United Church of Christ, the UAW, the International Association of Machinists, the United Steelworkers, the United Electrical Workers, the Older Women's League, and so many others that I do not have the time to list them.

I ask unanimous consent to insert a list in the RECORD of all the organizations representing millions and millions of Americans who are sick and tired of the current system and want to move toward a Medicare-for-all single-payer system.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

NATIONAL ORGANIZATIONS SUPPORT SINGLE PAYER

American Federation of Musicians of the United States and Canada, American Medical Students Association, Americans for Democratic Action, American Patients United, All Unions Committee for Single Payer Health Care, Alliance for Democracy, Business Coalition for Single Payer Health Care, California Nurses Association/National Nurse Organizing Committee, Coalition of Black Trade Unionists, Coalition of Labor Union Women, Committee of Presidents, National Association of Letter Carriers, Committees of Correspondence, Earthly Energy Werx, Electrical Workers Minority Caucus, Fellowship of Reconciliation, Feminist Caucus of the American, Humanist Association, and Global Kids Inc.

Global Security Institute, Health Plan Navigator, Healthcare NOW!, Hip Hop Caucus, House of Peace, Institute for Policy Studies, Cities for Progress, Inter-religious Foundation for Community Organization, International Association of Machinists and Aerospace Workers, League of Independent Voters, National Association for the Advancement of Colored People, National Association of Letter Carriers, National Council on Healthcare for the Homeless, National Economic and Social Rights Initiative, National Education Association, National Organization of Women, National Student Nurses Association, Needed Now, and Older Women's League.

PACE International Union, Peoples' Health Movement—US Circle, Physicians for a National Health Program, Progressive Christians Uniting, Progressive Democrats of America, The United Church of Christ, United Association of Journeymen & Apprentices of the Plumbing & Pipe Fitting Industry of the United States & Canada, United Automobile Workers, United Automobile Workers, International Union Convention, United Electric Workers, United Federation of Teachers, United Methodist Global Board of Church and Society, United Steelworkers of America, Up for Democracy, Women's Division of The United Methodist Church, Women's Universal Health Initiative, and Young Democrats.

STATE ORGANIZATIONS SUPPORT SINGLE PAYER

1199SEIU United Healthcare Workers East, MD, DC, NY, MA; 1199SEIU Retired Division of New York; American Guild of Musical Artists: Chicago/Midwest Region; American Postal Workers Union (APWU), Michigan State; Arizona AFL–CIO; Arkansas AFL-CIO; California State Pipe Trades Council, United Association; California School Employees Association; Connecticut State Council of Machinists of the IAMAW; Connecticut Medicare for All; Delaware State AFL–CIO; Florida CHAIN; Florida State AFL–CIO; Florida State Alliance for Retired Americans; Health Action New Mexico; Health Care for All California; Health Care for All Colorado; Health Care for All New Jersey; Health Care for All Texas; Health Care for All Washington; Hoosiers for a Common Sense Health Plan; and Iowa Federation of Labor; AFL–CIO.

Kentucky House of Representatives; Kentucky Jobs with Justice; Kentucky State AFL–CIO; Maine Council of United Steelworkers; Maine State AFL–CIO; Maine State Building & Construction Trades Council; Maryland State and District of Columbia AFL–CIO; Massachusetts Nurses Association; Massachusetts State United Auto Workers; Michigan State AFL–CIO Women's Council; Michigan State Association of Letter Carriers; Minnesota DFL Progressive Caucus; Minnesota State AFL–CIO; Missouri State AFL–CIO; New Jersey Media Corps; New Jersey State Industrial Union Council; New York Professional Nurses Union; New York State Nurses Association; North Carolina Fair Share; North Carolina State AFL–CIO; North Dakota State AFL–CIO; Ohio Alliance for Retired Americans.

Ohio State AFL–CIO; Ohio Steelworkers Organization of Active Retirees; Oregon United Methodist Church; Pennsylvania Association of Staff Nurses and Allied Professionals; Pennsylvania State AFL–CIO; SCFL of Wisconsin; SEIU—United Healthcare Workers West; South Carolina State AFL–CIO; South Dakota AFL–CIO; Texas AFL–CIO; Texas Alliance for Retired Americans; Texas Building & Construction Trades Council; The Tennessee Tribune Newspaper; Utah Jobs with Justice; Vermont State Labor Council AFLCIO; Washington State Alliance for Retired Americans; Washington State Building and Construction Trades Council; Washington State Labor Council; West Virginia State AFL–CIO; Wisconsin Clean Elections Campaign; Wisconsin State AFL–CIO; Wyoming State AFL-CIO.

Mr. SANDERS. There is also significant support in the House of Representatives for a single-payer system. Together, H.R. 676 and H.R. 1200, two different single-payer proposals, have 94 cosponsors.

And let me say a word about State legislatures that have moved forward aggressively toward a single-payer system. In California, our largest State, the State legislature there has on two occasions passed a single-payer program. The largest State in America passed a single-payer program, and on both occasions it was vetoed by the Governor. In New York State, the State Assembly passed a single-payer system. Among other States where single payer has been proposed and seriously discussed are Ohio, Massachusetts, Georgia, Colorado, Maine, Vermont, Illinois, Wisconsin, Oregon, Washington, New Mexico, Minnesota, Indiana, and New Hampshire.

Why is it that we need an entirely new approach for health care in this country? The answer is pretty obvious. Our current system, dominated by profit-making insurance companies, simply does not work. Yes, we have to confess, it does work for the insurance companies that make huge profits and provide their CEOs with extravagant compensation packages. Yes, it does work—and we saw how well it worked right here on the floor yesterday—for the pharmaceutical industry which year after year leads almost every other industry in profit while charging the American people by far—not even close—the highest prices in the world for prescription drugs.

So it works for the insurance companies. It works for the drug companies. It works for the medical equipment suppliers and the many other companies who are making billions of dollars off of our health care system. But it is not working for—in fact, it is a disaster for—ordinary Americans.

Today, 46 million people in our country have no health insurance and an even higher number of people are underinsured, with high deductibles or copayments. Today, as our primary health care system collapses, tens of millions of Americans do not have access to a doctor on a regular basis and, tragically, some 45,000 of our fellow Americans who do not have access to a doctor on a regular basis die every single year. That is 15 times more Americans who die of preventable diseases than were murdered in the horrific 9/11 attack against our country. That takes place every year: the preventable deaths of 45,000 people.

This is not acceptable. These horrific deaths are a manifestation of a collapsing system that needs fundamental change.

A number of months ago I took to the floor to relate stories that I heard from people throughout the State of Vermont regarding the health care crisis, stories which I published in a small pamphlet and placed on my Web site. Let me tell you one story.

A man from Swanton, VT, in the northern part of our State, wrote to me to tell me the story of his younger brother, a Vietnam veteran, who died 3

weeks after being diagnosed with colon cancer. At the time he was diagnosed, he had been laid off from his job and could not afford COBRA coverage. This is what his brother said:

When he was in enough pain to see a doctor it was too late. He left a wife and two teenage sons in the prime of his life at 50 years old. The attending physician said that, if he had only sought treatment earlier, he would still be alive.

Horrifically, tragically, that same story is being told in every State in this country over and over again. If only he had gone to the doctor in time he could have lived, but he didn't have any health insurance. That should not be taking place in the United States of America in the year 2009.

Our health care disaster extends beyond even the thousands who die needlessly every single year. Many others suffer unnecessary disability—strokes that leave them paralyzed because they couldn't afford treatment for their high blood pressure, or amputations, blindness, or kidney failure from untreated diabetes. Infants are born disabled because their mothers couldn't get the kind of prenatal care that every mother should have, and millions with mental illness go without care every single day.

In a town in northern Vermont not far from where I live, a physician told me that one-third of the patients she treats are unable to pay for the prescription drugs she prescribes. Think about the insanity of that. We ask doctors to diagnose our illness, to help us out, she writes the prescription for the drug, and one-third of her patients cannot afford to fill that prescription. That is insane. That is a crumbling health care system. The reason people cannot afford to fill their prescription drugs is that our people, because of pharmaceutical industry greed, are forced to pay by far the highest prices in the world for prescription drugs. This is indefensible. There is nobody who can come to the floor of this Senate and tell me that makes one shred of sense.

The disintegration of our health care system causes not only unnecessary human pain, suffering, and death, but it is also an economic disaster. Talk to small businesses in Vermont, New Hampshire, any place in this country, and they tell you they cannot afford to invest in their companies and create new jobs because all of their profits are going to soaring health care costs—10, 15, 20 percent a year. Talk to the recently bankrupt General Motors and they will tell you that they spend more money per automobile on health care than they do on steel. GM is forced to pay $1,500 per car on health care while Mercedes in Germany spends $419, and Toyota in Japan spends $97. Try to compete against that.

From an individual economic perspective, it is literally beyond comprehension that of the nearly 1 million people who will file for bankruptcy this year, the vast majority are filing for bankruptcy because of medically related illnesses. Let's take a deep breath and think about this from an emotional point of view. Let's think about the millions of people who are today struggling with cancer, struggling with heart disease, struggling with diabetes or other chronic illnesses. They are not even able to focus on their disease and trying to get well. They are summoning half their energy to fight with the insurance companies to make sure they get the coverage they need. That is not civilized. That is not worthy of the United States of America.

In my State of Vermont—and I suspect it is similar in New Hampshire and every other State—I have many times walked into small mom-and-pop stores and seen those little donation jars that say: Help out this or that family because the breadwinner is struggling with cancer and does not have any health insurance or little Sally needs some kind of operation and she doesn't have any health insurance, put in a buck or five bucks to help that family get the health care they need. This is the United States of America. This should and cannot be allowed to continue.

One of the unfortunate things that has occurred during the entire health care debate is that we have largely ignored what is happening in terms of health care around the rest of the world. I have heard some of my Republican colleagues get up and say: We have the best health care system in the world. Yes, we do, if you are a millionaire or a billionaire, but we do not if you are in the middle class, not if you are a working-class person, certainly not if you are low income. It is just not true.

Today, the United States spends almost twice as much per person on health care as any other country. Despite that, we have 46 million uninsured and many more underinsured and our health care outcomes are, in many respects—not all but in many respects—worse than other countries. Other countries, for example, have longer life expectancies than we do. They are better on infant mortality, and they do a lot better job in terms of preventable deaths. At the very beginning of this debate, we should have asked a very simple question: Why is it we are spending almost twice as much per person on health care as any other country with outcomes that, in many respects, are not as good?

According to an OECD report in 2007, the United States spent $7,290, over $7,000 per person on health care. Canada spent $3,895, almost half what we spent. France spent $3,601, less than half what we spent. The United Kingdom spent less than $3,000, and Italy spent $2,600 compared to the more than $7,000 we spent. Don't you think that maybe the first question we might have asked is: Why is it we spend so much and yet our health care outcomes, in many respects, are worse than other countries? Why is it that that happens?

Let me tell you what other people will not tell you. One key issue that needed to be debated in this health care discussion has not been discussed. The simple reason as to why we spend so much more than any other country with outcomes that are not as good as many other countries is that this legislation, from the very beginning, started with the assumption that we need to maintain the private for-profit health insurance companies. That basic reality that we cannot touch private insurance companies, in fact that we have to dump millions more people into private health insurance companies, that was an issue that could not even be discussed. And as a result, despite all the money we spend, we get poor value for our investment.

According to the World Health Organization, the United States ranks 37th in terms of health system performance compared with five other countries: Australia, Canada, Germany, New Zealand, and the United Kingdom. The U.S. health system ranks less or less than half.

Sometimes these groups poll people. They go around the world and they poll people and they ask: How do you feel about your own health care system? We end up way down below other countries. Recently, while the Canadian health care system was being attacked every single day, they did a poll in Canada. They said to the Canadian people: What do you think about your health care system? People in America say you have a terrible system. Do you want to junk your system and adopt the American system? By overwhelming numbers, the people of Canada said: Thank you, no thank you. We know the American system. We will stay with our system.

I was in the United Kingdom a couple months ago. I had an interesting experience. It was a Parliamentarian meeting. I met with a number of people in the Conservative Party—not the liberal Democratic Party, not the Labour Party, the Conservative Party, the party which likely will become the government of that country. The Conservatives were outraged by the kind of attacks being leveled against the national health system in their country, the lies we are being told about their system. In fact, the leader of the Conservative Party got up to defend the national health system in the United Kingdom and said: If we come to power, we will defend the national health system. Those were the conservatives.

What is the problem with our system which makes it radically different than systems in any other industrialized country? It is that we have allowed for-profit private corporations to develop and run our health care system, and the system that these companies have developed is the most costly, wasteful, complicated, and bureaucratic in the entire world. Everybody knows that. With 1,300 private insurance companies and thousands and thousands of different health benefit programs all designed to maximize profits, private

health insurance companies spend an incredible 30 percent of every health care dollar on administration and billing, on exorbitant CEO compensation packages, on advertising, lobbying, and campaign contributions. This amounts to some $350 billion every single year that is not spent on health care but is spent on wasteful bureaucracy.

It is spent on bureaucrats and on an insurance company telling us why we can't get the insurance we pay for. How many people today are on the phone today arguing with those bureaucrats to try to get the benefits they paid for? It is spent on staff in a physician's office who spend all their time submitting claims. They are not treating people; they are submitting claims. It is spent on hundreds of people working in the basement of hospitals who are not delivering babies, not treating people with cancer. They are not making people well. They are sending out bills. That is the system we have decided to have. We send out bills, and we spend hundreds of billions of dollars doing that rather than bringing primary health care physicians into rural areas, rather than getting the doctors, dentists, and nurses we need.

Let me give a few outrageous examples. Everyone knows this country is in the midst of a major crisis in primary health care. We lack doctors. We lack nurses. We lack dentists—a major crisis getting worse every single day. Yet while we are unable to produce those desperately needed doctors and nurses and dentists, we are producing legions of insurance company bureaucrats.

Here is a chart which deals with that issue. What this chart shows is that over the last three decades, the number of administrative personnel, bureaucrats who do nothing to cure our illnesses or keep us well, the number of bureaucrats has grown by 25 times the number of physicians. This is growth in the number of doctors—nonexistent. This is growth in the number of health care bureaucrats on the phone today telling you why you can't get the health care coverage you paid for or telling you that you have a preexisting condition and throwing you off health care because you committed the crime last year of getting sick. That growth is through the roof. This is where our health care dollars are going. This is why we need a single-payer system.

According to Dr. Uwe Reinhardt in testimony before Congress, Duke University Hospital, a very fine hospital, has almost 900 billing clerks to deal with hundreds of distinct managed care contracts. Do you know how many beds they have in that hospital? They have 900 beds. They have 900 bureaucrats involved in billing for 900 beds. Tell me that makes sense.

At a time when the middle class is collapsing and when millions of Americans are unable to afford health insurance, the profits of health insurance companies are soaring. From 2003 to 2007, the combined profits of the Nation's major health insurance companies increased by 170 percent. While more and more Americans are losing their jobs, the top executives of the industry are receiving lavish compensation packages. In 2007, despite plans to cut 3 to 4 percent of its workforce, Johnson & Johnson found the cash to pay its CEO Weldon $31.4 million. Ron Williams of Aetna took home over $38 million, and the head of CIGNA, Edward Hanway, took away $120 million over 5 years on, and on and on it goes.

So what is the alternative? Let me briefly describe the main features of a Medicare-for-all single-payer system. In terms of access, people getting into health care, this legislation would provide for all necessary medical care without cost sharing or other barriers to treatment. Every American—not 94 percent but 100 percent of America's citizens—would be entitled to care. In terms of choice, the issue is not choice of insurance companies that our Republican friends talk about. The question is choice of doctors, choice of hospitals, choice of therapeutic treatments. Our single-payer legislation would provide full choice of physicians and other licensed providers and hospitals. Importantly—and I know there is some confusion—a single-payer program is a national health insurance program which utilizes a nonprofit, private delivery system. It is not a government-run health care system. It is a government-run insurance program. In other words, people would still be going to the same doctors, still going to the same hospitals and other medical providers.

The only difference is, instead of thousands of separately administered programs run with outrageous waste, there would be one health insurance program in America for Members of Congress, for the poorest people in our country, for all of us. In that process, we would save hundreds of billions of dollars in bureaucratic waste. In terms of benefits, what would you get? A single-payer program covers all medically necessary care, including primary care, emergency care, hospital services, mental health services, prescriptions, eye care, dental care, rehabilitation services, and nursing home care as well. In terms of medical decisions, those decisions under a single-payer program would be made by the doctors and the patients, not by bureaucrats in insurance companies.

If we move toward a single-payer program, we could save $350 billion a year in administrative simplification, bulk purchasing, improved access with greater use of preventative services, and earlier diagnosis of illness.

People will be able to get to the doctor when they need to rather than waiting until they are sick and ending up in a hospital.

Further, and importantly, like other countries with a national health care program, we would be able to negotiate drug prices with the pharmaceutical industry, and we would end the absurdity of Americans being forced to pay two, three, five times more for certain drugs than people around the rest of the world.

Every other industrialized country on Earth primarily funds health care from broad-based taxes in the same way we fund the Defense Department, Social Security, and other agencies of government, and that is how we would fund a national health care program.

Let me be specific about how we would pay for this. What this legislation would do is, No. 1, eliminate—underline ''eliminate''—all payments to private insurance companies. So people would not be paying premiums to UnitedHealth, WellPoint, Blue Cross Blue Shield, and other private industry companies—not one penny. The reason for that is that private for-profit health insurance companies in this country would no longer exist.

Instead, this legislation would maintain all of the tax revenue that currently flows into public health programs like Medicare, Medicaid, and CHIP, and it would add to that an income tax increase of 2.2 percent and a payroll tax of 8.7 percent. This payroll tax would replace all other employer expenses for employee health care. In other words, employers in this country, from General Motors to a mom-and-pop store in rural America, would no longer be paying one penny toward private insurance revenue.

The income tax would take the place of all current insurance premiums, copays, deductibles, and all other out-of-pocket payments made by individuals. For the vast majority of people, a 2.2-percent income tax is way less than what they now pay for all of those other things. In other words, yes, you would be paying more in taxes. That is true. But you would no longer have to pay for private health insurance, and, at the end of the day, from both a financial perspective and a health security perspective, we would be better off as individuals and as a nation.

What remains in existence—I should add here—is the Veterans' Administration. I believe, and most of us believe, they have a separate set of issues, and the VA would remain as it is.

Let me bring my remarks to a close by giving you an example of where I think we should be going as a country in terms of health care. Oddly enough, the process that I think we should be using is what a small country of 23 million people—the country of Taiwan—did in 1995. In 1995, Taiwan was where we are right now—massive dissatisfaction with a dysfunctional health care system—and they did what we did not do. They said: Let's put together the best commission we can, the smartest people we know. Let's go all over the world. Let's take the best ideas from countries all over the world.

As Dr. Michael Chen, vice president and CFO of Taiwan's National Health Insurance Bureau, explained in an interview earlier this year, the Taiwanese ultimately chose to model their system—after a worldwide search—on

our Medicare Program. That is where they went, except that they chose to insure the entire population rather than just the elderly. After searching the globe, the Taiwanese realized what many Americans already know: a Medicare-for-all, single-payer system is the most effective way to offer quality coverage at a reasonable price.

Taiwan now offers comprehensive health care to all of its people, and it is spending 6 percent of its GDP to do that while we spend 16 percent of our GDP. But, unfortunately, the single-payer model was not ever put on the table here. Maybe we should learn something from our friends in Taiwan.

Let me end by saying this: This country is in the midst of a horrendous health care crisis. We all know that. We can tinker with the system. We can come up with a 2,000-page bill which does this, that, and the other thing. But at the end of the day, if we are going to do what virtually every other country on Earth does—provide comprehensive, universal health care in a cost-effective way, one that does not bankrupt our government or bankrupt individuals—if we are going to do that, we are going to have to take on the private insurance companies and tell them very clearly that they are no longer needed. Thanks for your service. We don't need you anymore.

A Medicare-for-all program is the way to go. I know it is not going to pass today. I know we do not have the votes. I know the insurance company and the drug lobbyists will fight us to the death. But, mark my words, Madam President, the day will come when this country will do the right thing. On that day, we will pass a Medicare-for-all single-payer system.

Mr. LUGAR. Mr. President, I take this opportunity to share with my colleagues a statement I have prepared regarding the health care reform debate in which the Senate is currently engaged.

A majority of the Members of Congress share President Obama's humane goal that millions more Americans might enjoy health insurance coverage and that medical care to all Americans might be substantially improved. For the moment, however, President Obama and the Congress must recognize that the overwhelming demand of most Americans is that presidential and congressional leadership should focus each day on restoration of jobs, strengthening of housing opportunities, new growth in small business and large industries, and banks that are not only solvent but confident of normal lending. In essence, the task facing national leadership is truly monumental. A national and international recession has not ended and many economists predict that unemployment, which has exceeded 10 percent in the United States, will continue to grow in coming months.

The President and the current Congress have realized a final deficit for fiscal year 2009 of $1.4 trillion, with the total national debt now at $12 trillion. The appropriation bills that Congress has passed and that will make up the next fiscal year's expenditures are predicted to result in another annual deficit of more than $1 trillion. In fiscal year 2009, Medicaid spending increased by 24.6 percent to $251 billion. Spending on Food Stamps increased 41 percent to $56 billion. Unemployment benefits increased almost 155 percent to $120 billion.

Republicans and Democrats may feel that passing comprehensive health legislation before the end of the year is crucial to the success or failure of the Obama administration and/or party leadership in the Congress.

But I would suggest that successful leadership will be defined, now and historically, by success in bringing a horrendous economic recession to an end, bringing new strength to our economy, and providing vital leadership in international relations as we hope to bring conflicts under control and in some cases, to conclusion.

I appreciate that President Obama has strongly argued that comprehensive health care legislation is an important component to reducing federal deficit spending. He has contended that failure to pass this legislation will increase deficits now and for many years to come. I disagree with the President.

After the economic recession in our country comes to a conclusion, a high priority may be extension of health insurance coverage and reform of many health care practices. When such changes occur, they are likely to be expensive and Americans will need to debate, even then, their priority in comparison to many other national goals. One reason why health care is likely to remain expensive is that major advances in surgical procedures, prescription drugs, and other health care practices have prolonged the lives of tens of millions of Americans and improved the quality of those additional years. The Washington Post, in a front-page story on July 26, 2009, mentioned that ''the fight against heart disease has been slow and incremental. It's also been extremely expensive and wildly successful.'' Americans should not take for granted all of the advances in health care that have enriched our lives, but we sometimes forget that we require and even pray for much more medical progress in years to come, which is likely to be expensive.

In order to pay for the cost of the nearly $1 trillion health care legislation, several Members of Congress are suggesting new forms of taxation, reduction of payments to doctors and hospitals, and curtailment of certain types of insurance coverage. These and other suggestions may temporarily bring about cost reduction but will also have some after-effects in the overall economy. In fact, strong financial incentives may be needed to enlist men and women to enter the medical field. Failure to enlist a sufficient number of doctors could lead to rationing of service and longer lines to find someone who will give humane attention.

In the meanwhile, it is possible that the President and Members of Congress might find some inexpensive, incremental improvements that could result in a greater number of Americans being served through health insurance and more efficiently operating health care institutions. The strong desire that most of us have to continue discussing these issues and make improvements need not be postponed even as President Obama and the Congress strive for victory over a devastating national economic recession.

Because our Federal spending deficits have risen so much and are predicted to rise even more, all substantive discussions on health care and other important issues will be conducted during many years of planning and, finally, decisive action to reduce deficit spending and preserve the value and integrity of the dollar as we continue to borrow hundreds of billions of dollars in the form of U.S. Treasury bonds sold to governments and citizens of other countries. They, too, are counting on the integrity of our dollar and our financial system to preserve the value of their financial reserves.

Starting with President Obama and extending to all Members of Congress, we wish that we had inherited a neutral, peaceful playing field. We have not been so fortunate. Our responsibility now is to recognize the extraordinary financial tragedy that has befallen our country and to recognize the unprecedented opportunity that we have to stop the momentum of that tragedy. We must provide valid hope of constructive vision, idealism, and change in the future. I look forward to working with the President and my colleagues to tackle first things first.

Ms. COLLINS. Madam President, I rise today to speak in favor of the motion to commit offered by Senators HUTCHISON and THUNE.

The Hutchison-Thune motion to commit would send the health care bill to the Senate Finance Committee with instructions to revise the bill in a revenue-neutral manner, to prevent taxes in the bill from going into effect before the exchanges are set up in 2014.

The bill makes Americans wait until 2014 to get insurance through the new ''exchanges,'' but it rolls out new tax hikes starting right away. Unless we take action to change this, Americans will see 4 years of tax increases before the chief benefits of this bill become available.

In the 4 years between now and the time the exchanges come online, Americans will face at least a dozen new or increased taxes and fees costing $73 billion.

Some of these taxes start in 2 weeks. For example, a new tax on pharmaceutical manufacturers, which will raise an average of $2.2 billion per year; a new tax on health insurance providers, which will raise $6.7 billion per

year; a new tax on medical device manufacturers, which will raise $2 billion per year.

Other taxes kick in 1 year from now. These include an increased penalty on withdrawals from Health Savings Accounts and a new $2,500 cap on FLEX spending accounts.

These new limits and penalties make no sense to me. Why would we want to impose a penalty on Americans who use money from their FLEX spending accounts to buy over-the-counter medicine? How is that going to help make health care more affordable?

But that is not all the bill does with respect to taxes. In 2013, the bill imposes several more taxes, including a reduction in the tax deductibility of medical expenses, a new high cost insurance excise Tax—the so-called Cadillac tax, and an increase in the Medicare payroll tax for high earners.

These tax increases total $73 billion before 2014, before anyone gets a dollar of subsidy to purchase health insurance in the new exchanges.

These taxes will be paid right away by Americans in the form of higher health insurance premiums. This is not just my opinion; this is what the Congressional Budget concludes too. Here is what the CBO said about the $6.7 billion annual fee on health insurance providers, which is scheduled to begin next year:

We expect a very large portion of [the] proposed insurance industry fee to be borne by purchasers of insurance in the form of higher premiums.

It is not just taxes on insurance that will be passed on to consumers. Taxes on pharmaceutical manufacturers and medical devices makers will also be passed on.

This means that American consumers will see price increases for everything from insulin pumps, to pacemakers, to power wheelchairs and drugs like Prilosec.

As the CBO Director has said:

Those fees would increase costs for the affected firms, which would be passed on to purchasers and would ultimately raise insurance premiums by a corresponding amount.

The Joint Committee on Taxation shares the CBO's view these tax hikes will be passed along to consumers.

Once again, I do not see how imposing these new taxes now—before the exchanges are set up and the chief benefits of the bill are supposed to become available—makes health care more affordable.

For all of these reasons, I will be voting in favor of the Hutchison-Thune motion to recommit, and I would urge my colleagues to do the same.

MOTION TO COMMIT

Mr. SANDERS. Madam President, I now move to table Senator HUTCHISON's motion to commit, and I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There appears to be a sufficient second.

The question is on agreeing to the motion.

The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. DURBIN. I announce that the Senator from West Virginia (Mr. BYRD) and the Senator from Massachusetts (Mr. KERRY) are necessarily absent.

Mr. KYL. The following Senator is necessarily absent: the Senator from Oklahoma (Mr. INHOFE).

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 56, nays 41, as follows:

[Rollcall Vote No. 379 Leg.]

YEAS—56

Akaka	Gillibrand	Murray
Baucus	Hagan	Nelson (FL)
Begich	Harkin	Pryor
Bennet	Inouye	Reed
Bingaman	Johnson	Reid
Boxer	Kaufman	Rockefeller
Brown	Kirk	Sanders
Burris	Klobuchar	Schumer
Cantwell	Kohl	Shaheen
Cardin	Landrieu	Specter
Carper	Lautenberg	Stabenow
Casey	Leahy	Tester
Conrad	Levin	Udall (CO)
Dodd	Lieberman	Udall (NM)
Dorgan	Lincoln	Warner
Durbin	McCaskill	Webb
Feingold	Menendez	Whitehouse
Feinstein	Merkley	Wyden
Franken	Mikulski	

NAYS—41

Alexander	Crapo	McCain
Barrasso	DeMint	McConnell
Bayh	Ensign	Murkowski
Bennett	Enzi	Nelson (NE)
Bond	Graham	Risch
Brownback	Grassley	Roberts
Bunning	Gregg	Sessions
Burr	Hatch	Shelby
Chambliss	Hutchison	Snowe
Coburn	Isakson	Thune
Cochran	Johanns	Vitter
Collins	Kyl	Voinovich
Corker	LeMieux	Wicker
Cornyn	Lugar	

NOT VOTING—3

Byrd	Inhofe	Kerry

The motion was agreed to.

Mr. REID. Madam President, I move to reconsider the vote, and I move to lay that motion on the table.

The motion to lay on the table was agreed to.

(At the request of Mr. REID, the following statement was ordered to be printed in the RECORD.)

VOTE EXPLANATION

● Mr. KERRY. Madam President, I was necessarily absent for the vote on the motion to table the Hutchison motion to commit to the health care bill, H.R. 3590. If I were able to attend today's session, I would have voted to table the Hutchison motion to commit.●

DEPARTMENT OF DEFENSE APPROPRIATIONS ACT, 2010

Mr. REID. Madam President, I ask the Chair to lay before the Senate a message from the House with respect to H.R. 3326, the Department of Defense Appropriations Act.

The PRESIDING OFFICER. The Chair lays before the Senate the message from the House.

H.R. 3326

Resolved, That the House agree to the amendment of the Senate to the bill (H.R. 3326) entitled ''An Act making appropriations for the Department of Defense for the fiscal year ending September 30, 2010, and for other purposes'', with a House amendment to Senate Amendment.

CLOTURE MOTION

Mr. REID. Madam President, I move to concur in the House amendment, and I send a cloture motion to the desk.

The PRESIDING OFFICER. The clerk will report the motion.

The legislative clerk read as follows:

CLOTURE MOTION

We, the undersigned Senators, in accordance with the provisions of rule XXII of the Standing Rules of the Senate, hereby move to bring to a close debate on the motion to concur in the House amendment to the Senate amendment to H.R. 3326, the Department of Defense Appropriations Act for Fiscal Year 2010.

Daniel K. Inouye, Harry Reid, Max Baucus, Patrick J. Leahy, Sheldon Whitehouse, Carl Levin, Patty Murray, Mark Begich, Maria Cantwell, Mark L. Pryor, Jack Reed, Edward E. Kaufman, Al Franken, Tom Harkin, Jim Webb, Paul G. Kirk, Jr., Michael F. Bennet.

AMENDMENT NO. 3248

Mr. REID. Madam President, I move to concur in the House amendment with an amendment, which is at the desk.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Nevada (Mr. REID) moves to concur in the House amendment to the Senate amendment with an amendment numbered 3248.

Mr. REID. Madam President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

At the end of the House amendment, insert the following:

The provisions of this Act shall become effective 5 days after enactment.

Mr. REID. Madam President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

AMENDMENT NO. 3252 TO AMENDMENT NO. 3248

Mr. REID. Madam President, I have an amendment at the desk.

The PRESIDING OFFICER. The clerk will report.

The Senator from Nevada (Mr. REID) proposes an amendment numbered 3252 to amendment No. 3248.

Mr. REID. I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

Strike ''5 days'' and insert ''1 day''.

MOTION TO REFER/AMENDMENT NO. 3249

Mr. REID. Madam President, I have a motion to refer, with instructions, at the desk.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Nevada (Mr. REID) moves to refer H.R. 3326 to the Committee on Appropriations with instructions to report back with the following amendment No. 3249:

At the end, insert the following:

The Appropriations Committee is requested to study the impact of any delay in implementing the provisions of the Act on service members' families.

Mr. REID. Madam President, I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

AMENDMENT NO. 3250

Mr. REID. Madam President, I have an amendment to my instructions at the desk.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Nevada (Mr. REID) proposes an amendment numbered 3250 to the instructions of amendment No. 3249.

Mr. REID. Madam President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

At the end, add the following:

''and the health care provided to those service members.''

Mr. REID. Madam President, I ask for the yeas and nays on the amendment.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

AMENDMENT NO. 3251 TO AMENDMENT NO. 3250

Mr. REID. Madam President, I have a second-degree amendment at the desk.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Nevada (Mr. REID) proposes an amendment numbered 3251 to amendment 3250.

Mr. REID. Madam President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

At the end, add the following:

''and the children of service members.''

Mr. REID. Madam President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. DURBIN. Madam President, I ask unanimous consent that the order for the quorum call be rescinded.

Mr. ENSIGN. I object.

The PRESIDING OFFICER. Objection is heard. The clerk will continue calling the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. REID. Madam President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. REID. It is my understanding that the Senator from Texas wishes to speak for up to 5 minutes. I ask unanimous consent that she be recognized, and following that Senator DURBIN be recognized.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from Texas is recognized.

Mrs. HUTCHISON. Madam President, I thank the majority leader for allowing me to speak because I am very concerned about a precedent that has been set on the floor in this last vote.

When the Senator from Vermont withdrew his amendment and started talking, my motion to commit was the measure pending on the floor. I did not have notice—which is the normal procedure here—to be able to talk on my motion. We had no idea there would be a motion to table my motion before I had a chance to close.

Here is my point. The measure that was tabled, the Hutchison-Thune motion, would have assured the American people that there would not be 4 years of tax collection before any kind of program would be put forward under the health care reform package. I thought it was very important that Senator THUNE and I be able to close on that. That is a concept we have always had in the Senate—that a program starts when it starts. That means if taxes are included, the taxes will start when the program starts. That is not the case in the underlying bill. The underlying health care reform bill has 4 years of taxes. There will be taxes on insurance companies that will surely raise the premium of every insurance policy in America. There are taxes on prescription drug companies, so that prescription drug prices will surely go up. There are taxes on medical device companies, so the prices on health care equipment will also go up. How much are we talking about? We are talking about $100 billion in taxes that will start in 3 weeks—in January of 2010. Again, we are looking at taxes that will start in 3 weeks, next month, which will accumulate up to $73 billion before a program is implemented that will give anyone a choice of an affordable health care option.

That is the motion that was tabled 10 minutes ago. I want to make sure everyone knows I never had a chance to close on the motion. Senator THUNE didn't have a chance to close, because it was a motion made that could not be objected to. That is not the way things have operated here in the past, and I think it is time we bring back the traditions of the Senate, where we have time that we agree to, everybody has their say, and then we go forward.

I am very concerned about that process. I hope it is not setting precedent because I think we can resurrect health care reform if we have a bipartisan health care effort. If we have an effort that will bring down the costs, that will increase the risk pools so that an employer will be able to afford to offer employees health care coverage, bring down the costs of health care with medical malpractice reform that would save $54 billion in the system, we can do things without a government takeover of health care. But the bill that is before us has $½ trillion in Medicare cuts—Medicare cuts, $½ trillion—and $½ trillion in new taxes—taxes on businesses that offer not enough coverage, businesses that offer too much coverage, a 40-percent excise tax on policies that give what is called Cadillac coverage, the high benefit plans. So if you have a good insurance policy, you have a 40-percent tax on top of the premium you pay. And if you have too little coverage, you also get taxed. You are whipsawed in this bill.

I think the small business people of this country know what this bill is about because that is the comment we are getting. They are the people calling into our offices. They are the people I see on the airplanes as I go back and forth to try to make sure we are covering the bases on this bill and trying to let the American people know what is in it.

I am concerned about the precedent that was set, but more than that, I am concerned that the American people must know that if this bill passes as it is on the floor today, the taxes will take effect in 3 weeks, that insurance premiums will surely go up, prescription drugs will surely go up, prices on medical equipment will surely go up, and there will not be an affordable insurance plan for people to choose to take for 4 years. It is like buying a house and having the mortgage company hand you the keys and say: Come back in 4 years, and we will let you unlock the door.

I don't think that is transparency, and it is certainly not health care reform. I hope there is still a chance that we can bring this body to a bipartisan effort that will allow lower premiums, more health care options for the people of this country but, most important, that will keep the quality of health care, the choices we have in health care that Americans have come to expect and not start going on the road to a single-payer system because in the end, that is what the bill before us will lead to. It will be a single-payer system. It will take choices out. It will take quality out.

It will add taxes and burdens on our small businesses at a time when they need to be able to hire people to get our economy going and to get that jobless rate down. We need them to employ people. We need to encourage our employers to employ people. They cannot do it if we put more taxes and burdens on them, which is what the bill before us does.

I thank the majority leader for allowing me to speak since I did not have a chance to speak before my motion was tabled. I hope the American people

are listening because we have a chance to do this right. The bill on the floor today is not that bill.

I yield the floor.

The PRESIDING OFFICER (Mr. BURRIS). The Senator from Illinois is recognized.

Mr. DURBIN. Mr. President, I thank the Senator from Texas. I am glad she had an opportunity to speak. We disagree on this issue, but I am glad she had her opportunity to speak.

I hear from different people. Obviously, we must ride on different planes because the people I speak with are anxious to see some change in this health care system and know that 14,000 Americans lose their health insurance every single day. They know that most people cannot afford health insurance because of the increase in costs.

I say to the Senator from Texas, she is my friend and we have worked on many issues in the past, but we disagree on this issue.

I am coming before the Senate with a holiday proposal. Recently there was a book that was published about World War I. It was about trench warfare that went on and on with horrendous casualties and lives being lost. Then there came a moment, a Christmas moment, when they decided to call a truce because of Christmas and play a soccer game. The Allied and Axis troops came out and, for a brief moment, stopped the war, played the soccer game, and went back to the trenches and the next day started shooting again.

I am looking for a holiday truce here for our troops because what we have before us right now is the Department of Defense appropriations bill. Although Senator HUTCHISON and I clearly disagree and many Members on both sides clearly disagree when it comes to health care, there is no disagreement when it comes to our troops. Every one of us supports our troops. Every one of us wants to make sure they have what they need, the resources they need to perform their mission successfully and come home safely.

This bill that is before us, this Department of Defense appropriations conference report, is an attempt for us to do something to help these troops in time of war. I would hope I could appeal to my colleagues on the other side of the aisle that for one brief, shining moment in the spirit of the holiday we set aside our political differences for the sake of our men and women in uniform.

The point I am getting to is that if we go through the ordinary, tortured procedure and wait, it is going to take us days to complete this bill for our troops. I hope we can show good faith on both sides of the aisle and overcome that. I hope we could enter into a consent agreement among Republicans and Democrats because I know as I stand here that the Republicans feel as the Democrats do—that we should provide funding for our overseas operations of our men and women in uniform.

In this bill, $101 billion is included for operations and maintenance for ongoing military operations in Iraq and Afghanistan and to support the preparations to continue the withdrawal from Iraq.

In this bill, there is $23.36 billion for equipment. We want to make sure our men and women in uniform have the equipment they need to make certain they are safe and have what they need to come home safely.

There is also a pay raise in this bill, a 3.4-percent pay raise. Does anyone dispute the need that our military has to be recognized for what they have given our country and be given a pay raise?

When it comes to readiness and training, there is $154 billion for the defense operation and maintenance account to increase readiness.

In the field of military health care, there is $29 billion for the Defense Health Program to provide quality care for servicemembers and their families. It includes, incidentally, $120 million for traumatic brain injury and psychological health research.

These are issues we have all come together on. We are not arguing about these issues, and I do not think we should at this moment.

There is $472 million for family advocacy programs and full funding for Family Support and Yellow Ribbon to provide support to military families, including quality childcare, job training for spouses, and expanded counseling and outreach.

There is one other section of the bill—and I will yield for a question from my friend from Alaska when I complete this point—there is one other section that relates to the unemployment crisis facing this country. It is a modest extension of the unemployment benefits. The last time it was on the floor, I believe it passed 97 to 0. I do not believe there is any controversy to the fact that we want to extend unemployment insurance benefits through February 28 of next year. It is difficult to envision a situation where we would actually leave here to go home to our families for the holidays and not take care of the unemployed.

There is also a provision for their health insurance under COBRA and for food stamps on which we know so many unemployed families rely. It seems to me if there is one thing in the midst of this political turmoil we can agree on, it is let's stand behind our troops, let's make sure people who are unemployed have a happy holiday season. Why do we want a tortured process to reach a ''yes'' on this conference report? I appeal to my colleagues on the other side of the aisle to make this a bipartisan effort. Let's do this part. We can return to the health care bill and the debate. But let's get this done and do it without all the necessary motions and time that may be spent.

I yield for a question from the Senator from Alaska.

The PRESIDING OFFICER. The Senator from Alaska is recognized.

Mr. BEGICH. Mr. President, I appreciate the Senator from Illinois bringing up what I consider a very most important piece of legislation to Alaska. Eleven percent of our population are veterans. We have thousands of military individuals in our State.

I am new to the process. One of the questions I have for the Senator—and I hope he can enlighten me and also enlighten the whole public watching—this is probably one of the most important departments at this time. We are in two wars. Can the Senator give me an explanation? In the past—Senator DURBIN started to do it—the Defense bill seemed to be one of those bills where we all came together. It is a bipartisan approach. I know as members of the Armed Services Committee, it seems every time we deal with these issues we are unified.

Help me to understand why this is something that seems to be controversial and yet should be so simple for us to do.

Mr. DURBIN. I say in response to the Senator from Alaska, I think it is the moment. If we were in a different political environment, I think the Republican Senators and Democratic Senators would agree that this should go through and go through quickly. But we have been caught up for weeks now in debate and controversy, and this bill has been tossed into that environment. That is the explanation because I do not think there is a single provision I read here that Republican Senators do not support, as the Democratic Senators support. That is why I made my suggestion.

Mr. BEGICH. Mr. President, if I may ask one more question. That last statement the Senator from Illinois made, I know as a member of the Armed Services Committee, I have not heard complaints about this bill from anyone from the other side. I am asking, from a leadership position, have we heard any complaints on this legislation? Is it just that, it is the moment in time?

Mr. DURBIN. I say in response to the Senator from Alaska, it does include some provisions relative to the unemployed. There were other things that could have been included by the House, but we reached out to the Republican side and asked: Are any of these problematic? By and large, they said here are the things you should not include, and we did not. We did our best to ensure we brought a noncontroversial bill for consideration.

Mr. BEGICH. I thank the Senator.

Ms. STABENOW. Will the Senator yield for a question?

Mr. DURBIN. I am happy to yield to the Senator from Michigan.

Ms. STABENOW. Mr. President, from the Senator's explanation and from what we have been working on, I want the Senator to clarify two things.

First of all, we could do this conference report today if there were a willingness and, secondly, we have a pay raise for our troops that is coming right before Christmas, the holidays,

help for families, help for those who have lost their jobs and are trying to figure out how they keep their health care going, and help for people who are trying to put food on the table for the holidays; is that correct? I ask the Senator to expand. As I understand it, we could actually get this done today and give people some peace of mind going into the holidays.

Mr. DURBIN. I say to the Senator from Michigan, yes, we could enter into a consent agreement now and pass this conference report without controversy, and I bet you it would get a unanimous vote.

As the Senator from Michigan described this, everybody here wants to make sure we take care of our troops. We received a unanimous vote, if memory serves me, the last time we extended unemployment benefits. I think most Members want to stand up and help those who are unemployed through this difficult time of unemployment in our country.

If there ever were a bill to bring us together in those two areas—helping our troops and helping the unemployed—this is the bill.

Ms. STABENOW. Mr. President, I wish to ask another question of the Senator from Illinois. If, in fact, the Senator from Illinois is finding the same thing I am right now—certainly, we have the highest unemployment rate in Michigan—and we are hearing it from all over the country; we are hearing from people that their unemployment benefits are about to expire. They are trying to figure out how they are going to make it through the next few months.

There are particular concerns that if we do not extend it by the end of the year that, in fact, many will have to go out and resign up with a new bureaucracy to continue benefits.

I wonder if the Senator has heard the same kinds of concerns and sense of urgency people have about being able to keep a roof over their head, keep food on the table, and keep their health care going—the same sense of urgency that I know we are feeling from people in Michigan?

Mr. DURBIN. I say in response to the Senator from Michigan, through the Chair, that I am happy to read the latest unemployment statistics showing the number of people declared unemployed each month is going down. We will not feel good about it until it is turned around and we are creating jobs again, which I hope is soon.

In the meantime, we have about six unemployed people for every job that is available. These people are in a market that is terrible, and they are trying their best. Some have gone back to school. Some are getting training courses. Some are trying to keep things together with their family and not lose their home because of unemployment.

I am sure the Senator from Michigan has met with the unemployed in Michigan, as I have in Illinois. Some are, little by little, exhausting the savings they have. Even with COBRA, many people find the COBRA provision, which gives people a chance to buy insurance at discounts, is still too expensive. They are without a job. They are running the risk of losing their home. They are without health insurance for their children and are desperately looking for a job. We certainly do not want to put them in a situation where there is a question mark as to whether after December 31 the unemployment check will be there next month. I think it is that peace of mind we owe these folks caught up in the bad circumstances of our economy.

Ms. STABENOW. If I may conclude, to clarify, we can get this done today. We can create that peace of mind for families going into the holidays, going into Christmas, into the end of the year. We could actually do that today in the next few hours?

Mr. DURBIN. That is correct, I say to the Senator from Michigan, we can. Earlier we were embroiled in the reading of an amendment that would have literally consumed the entire day and forced us into another day's time and run the risk of not providing money for the troops when the continuing resolution, the funding resolution, ran out.

The Senator from Vermont withdrew his amendment, and now we have moved to this bill. But there is nothing stopping us. A consent agreement can be entered into by both sides of the aisle that can move this through quickly and say to our troops: We are with you.

I yield to the Senator from Rhode Island.

Mr. WHITEHOUSE. Mr. President, will the Senator from Illinois yield for a question?

Mr. DURBIN. I will be happy to yield.

Mr. WHITEHOUSE. I am interested in the parliamentary situation that took place earlier whereby one of our Members was actually obliged to withdraw an amendment that was going to be voted on by all of us because of an insistence on the part of the other side that 800 pages be read by our poor clerk before that vote should take place.

I have also heard the other side say that we want to get going, we want to move toward votes. I would be interested in the reflections of the distinguished majority whip on the extent to which a procedural objection to force the clerk to read 800 pages of an amendment, and deny one of our colleagues his vote, fairly represents a desire to move forward and get through our votes.

Mr. DURBIN. I would say in response to the Senator from Rhode Island, we have heard repeatedly that people want amendment, debate, and a vote. What happened on the floor today, when Senator COBURN of Oklahoma refused to give consent to suspending the reading of the amendment, is that the clerk—clerks, I should say—were forced to start reading. As good as they are at reading, the fact is, it was going to take up to 10 hours to read this amendment. During that 10-hour period of time, nothing could happen—no debate, no amendments—nothing other than listening to the clerks' melodious voices. Fortunately for us, the Senator from Vermont stepped up and said: I withdraw the amendment. But if there was a true interest in debate and amendments on health care, it is inconsistent to say we are going to take a day out of the whole affair and read an amendment.

I can tell you, as I said to the Senator from Oklahoma, I can't believe there is a person in America who sat glued to the C–SPAN television listening to this amendment so they would understand it. It is a very complicated amendment page by page but, in general, understandable. The Senator from Vermont was seeking a single-payer health care system. It was not likely to pass, but it is something he believes in fervently and he wanted to offer it. So I would say the strategy on the floor today belies any request that we have more debate and more amendments.

Before the Senator from Rhode Island continues, I think this has been cleared on both sides, but I ask unanimous consent that the time until 6:15 p.m. be equally divided between the two sides, with Senators permitted to speak for up to 15 minutes each.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. WHITEHOUSE. If the Senator from Illinois would yield for another question.

I was elected just about 3 years ago, and I came in with the new majority, so I did not have a chance to serve in this body when there was a Republican President and a Republican majority. I wonder if the Senator, who was here at that time, would reflect on how the other side viewed Defense appropriations for our troops during the Iraq war when they were in the majority. Were they desirous of delay and obstruction and debate and procedural maneuver on Defense appropriations at that time or is this a new strategy of theirs?

Mr. DURBIN. I would say to my colleague from Rhode Island that exactly the opposite was true. They wanted to move quickly to pass any appropriations bill to make certain there was no question in the minds of our men and women in uniform that we were standing with them, and we did. I don't believe even those of us who voted against the invasion of Iraq tried to stop the proceedings from funding the troops, regardless of what our votes might be.

So I think it would be consistent now for our colleagues on the other side of the aisle to join us, in a bipartisan fashion, to say whatever differences on other issues, such as health care, let's let the troops know this holiday season we stand behind them—Republicans and Democrats—and let's do it in an efficient and effective way.

Since this unanimous consent request has been granted, I am going to

yield the floor and any of my colleagues who wish to speak, it will be equally divided time for the next 2 hours.

At this time, I yield the floor. Mr. President, if no one seeks time, I suggest the absence of a quorum and I ask unanimous consent that during the time of the quorum the time be equally divided between both sides.

The PRESIDING OFFICER. Without objection, it is so ordered. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. LEMIEUX. Mr. President, I ask unanimous consent the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered. The Senator from Florida is recognized.

Mr. LEMIEUX. Mr. President, while we have been here discussing health care, the clock has been ticking on our national debt. Just in the first 2 months of this fiscal year, we have accumulated $296 billion in debt. We took in revenues of $268 billion, and we spent $565 billion. We spent double what we took in just in the first 2 months of the fiscal year.

I know you are new to this Chamber, Mr. President, as am I. I have only been here 90 days, but I have been here long enough to know this system is broken. It doesn't work. Neither this body nor the body across the Capitol has an ability to make ends meet. We continue to spend money we do not have. We spend the money of our children and our grandchildren. Right now we have a $12 trillion debt. It took us 167 years in this country just to amass a $1 trillion debt in 1982. Now we are at $12 trillion. Every family in this country is now responsible for $100,000 of debt.

Where are we getting this money? We are borrowing it from countries such as China, and it is hurting our standing in the world. Central banks that hold American currency are shedding those dollars because they no longer believe our country is a good investment. I worry about our children and our grandchildren. I have three sons, as you know, Max, Taylor and Chase—they are 6, 4 and 2—and we have a baby on the way in March. I am very worried that my children will not be able to experience the American dream like you and I have; to be able to be in the Senate, to be able to achieve all of our goals, whether in public service or in private. I do not believe America is going to be the same place for them, that it is going to hold the same opportunities because I believe this debt is going to strangle us.

If this body and the body across the Capitol don't figure out we need to start making ends meet and stop spending the dollars of future generations, this country will not be the leader of the world. It will not have the promise we have all enjoyed.

I rise today to speak about S.J. Res. 22, which I filed yesterday. It is a constitutional amendment that requires the Congress to balance its budget and also gives to the President of the United States a line-item veto so he, like most of the Governors in this country, can strike out inappropriate budget items, these earmarks that you hear about.

Senator MCCAIN spoke this weekend about $2.5 million to the University of Nebraska to study operations and medical procedures in space. We cannot afford that program under any circumstance, and we certainly can't afford programs like that when we are $12 trillion in debt. These dollar numbers are so big they are hard to comprehend.

What does $1 trillion mean? What does $1 billion mean? In Washington we throw these amounts around, and we do not even comprehend them. I know for the American people at home it is hard to get their minds around how much money this is. I have said this on the Senate floor before, and I am going to keep saying it so people understand that every dollar we spend is a choice.

One million dollars laid edge to edge on the ground would cover two football fields. One billion dollars laid edge to edge on the ground would cover the city of Key West, FL, 3.7 square miles. And $1 trillion would cover the State of Rhode Island—twice. If you stacked them on the ground going up into the sky, it would be 600 miles of one-dollar bills.

Every dollar is a choice, and these numbers are out of control. Just this past Saturday we voted on a spending bill, a spending bill that had a 12-percent increase and $40 billion more than last year. I want to give the American people the sense of what you could do with this kind of money, what good you could do or, better yet, you could give it back to the American people and they could decide what good they could do with those dollars for their families.

With $100 billion, we could give every Floridian a $5,000 tax cut.

With $200 billion we could pay the salary of every teacher for a year. With $300 billion we could pay first-year tuition at a university of their choice for every kid who is in K–12. With $400 billion, we could build high-speed rail for 10,000 miles. We could connect Key West to Anchorage and back.

Every dollar is a choice. We are spending money out of control. Similar to those who have come before me, I will sound the alarm because we still haven't done anything about this problem. There are good measures out there. Senator GREGG from New Hampshire has a measure, along with Senator CONRAD, to put together a commission. I support that. Senator SESSIONS has a measure to bring caps back. Up until about 2002, we actually were making headway against the budget. Then those caps expired and spending went out of control.

I support all those efforts. I support any effort to bring spending under control. This body doesn't have any leadership on spending. Look at what we spend. We don't look at the revenues coming in the door.

I served as chief of staff to a Governor in Florida. When the budget started to go bad in 2007, I was on the phone monthly with the person who determined our receipts. I knew in Florida we could only spend as much money as we had. This institution does not work that way. No one even checks to see what kind of money we are bringing in. We just spend.

I wish to talk to the American people about articles in the Wall Street Journal of today. This is not a Democratic problem or a Republican problem. This is a problem of this institution. The article is titled ''The Audacity of Debt.'' I wish to read one paragraph. I ask unanimous consent that the full article be printed in the RECORD.

There being no objection, the material was ordered to be printed in the Record, as follows:

[From the Wall Street Journal, Dec. 16, 2009]

THE AUDACITY OF DEBT

COMPARING TODAY'S DEFICITS TO THOSE IN THE 1980S

At least someone in America isn't feeling a credit squeeze: Uncle Sam. This week Congress will vote to raise the national debt ceiling by nearly $2 trillion, to a total of $14 trillion. In this economy, everyone deleverages except government.

It's a sign of how deep the fiscal pathologies run in this Congress that $2 trillion will buy the federal government only one year before it has to seek another debt hike—conveniently timed to come after the midterm elections. Since Democrats began running Congress again in 2007, the federal debt limit has climbed by 39 percent. The new hike will lift the borrowing cap by another 15 percent.

There is surely bipartisan blame for this government debt boom. George W. Bush approved gigantic spending increases for Medicare and bailouts. He also sponsored the first ineffective''stimulus'' in February 2008—consisting of $168 billion in tax rebates and spending that depleted federal revenues in return for no economic lift.

Democrats ridiculed Mr. Bush as ''the most fiscally irresponsible President in history,'' but then they saw him and raised. They took an $800 billion deficit and made it $1.4 trillion in 2009 and perhaps that high again in 2010. In 10 months they have approved more than $1 trillion in spending that has saved union public jobs but has done little to assist private job creation. Still to come is the multitrillion-dollar health bill and another $100 billion to $200 billion ''jobs'' bill.

We've never obsessed over the budget deficit, because the true cost of government is the amount it spends, not the amount it borrows. Milton Friedman used to say that the nation would be far better off with a budget half the current size but with larger deficits. Mr. Obama and his allies in Congress have done the opposite: They have increased the budget by 50 percent and financed the spending with IOUs.

Our concern is that the Administration and Congress view this debt as a way to force a permanently higher tax base for decades to come. The liberal grand strategy is to use their accidentally large majorities this year to pass new entitlements that start small but will explode in future years. U.S. creditors will then demand higher taxes—taking

income taxes back to their pre-Reagan rates and adding a value-added tax too. This would expand federal spending as a share of GDP to as much as 30 percent from the pre-crisis 20 percent.

Remember the 1980s and 1990s when liberals said they worried about the debt? We now know they were faking it. When the Gipper chopped income and business tax rates by roughly 25 percent and then authorized a military build-up, Democrats and their favorite economists predicted doom for a decade. The late Paul Samuelson, the revered dean of the neo-Keynesians, expressed the prevailing view in those days when he called the Reagan deficits ''an all-consuming evil.''

But wait: Those ''evil'' Reagan deficits averaged less than $200 billion a year, or about one-quarter as large in real terms as today's deficit. The national debt held by the public reached its peak in the Reagan years at 40.9 percent, and hit 49.2 percent in 1995—This year debt will hit 61 percent of GDP, heading to 68 percent soon even by the White House's optimistic estimates.

Our view is that there is good and bad public borrowing. In the 1980s federal deficits financed a military buildup that ended the Cold War (leading to an annual peace dividend in the 1990s of 3 percent of GDP), as well as tax cuts that ended the stagflation of the 1970s and began 25 years of prosperity. Those were high return investments.

Today's debt has financed . . . what exactly? The TARP money did undergird the financial system for a time and is now being repaid. But most of the rest has been spent on a political wish list of public programs ranging from unemployment insurance to wind turbines to tax credits for golf carts. Borrowing for such low return purposes makes America poorer in the long run.

By the way, today's spending and debt totals don't account for the higher debt-servicing costs that are sure to come. The President's own budget office forecasts that annual interest payments by 2019 will be $774 billion, which will be more than the federal government will spend that year on national defense, education, transportation—in fact, all nondefense discretionary programs.

Democrats want to pass the debt limit increase as a stowaway on the defense funding bill, hoping that few will notice while pledging to reduce spending at some future date. Republicans ought to force a long and careful debate that educates the public. Ultimately, the U.S. government has to pay its bills and the debt limit bill will have to pass. But debt limit votes are one of the few times historically when taxpayer advocates have leverage on Capitol Hill. Republicans and Democrats who care should use it to discuss genuine ways to put Washington on a renewed and tighter spending regime.

''Washington is shifting the burden of bad choices today onto the backs of our children and grandchildren,'' Senator Barack Obama said during the 2006 debt-ceiling debate. ''America has a debt problem and a failure of leadership. Americans deserve better.'' That was $2 trillion ago, when someone else was President.

Mr. LEMIEUX. Reading from the Wall Street Journal:

Democrats ridiculed Mr. Bush as ''the most fiscally irresponsible President in history,'' but then they saw him and raised. They took an $800 billion deficit and made it $1.4 trillion in 2009 and perhaps that high again in 2010. In 10 months they have approved more than $1 trillion in spending that has saved union public jobs but has done little to assist private job creation. Still to come is this multitrillion-dollar health care bill and another $100 billion to $200 billion ''jobs'' bill.

We can't afford the programs we have, let alone the programs we want. I filed this joint resolution to have a balanced budget. I filed the joint resolution to give the President the line-item veto like Governors do. I know I am tilting at windmills. I know there are very few people in this Chamber or the Chamber down the hall who have the courage to do this. They are part of the process. They go along and get along. But I am fresh enough to still remember how things work in the real world. We have to change things. Our children are not going to have this great country. I am so afraid that one of my kids is going to come to me when they are 18 or 22 and say: Dad, I am going to go to another country to make my living. I am going to go to Ireland or Chile or India because I have a better opportunity there to succeed. I can't pay 60 percent in taxes. I can't assume what will then be a $23 or $30 billion debt.

We are not even talking about all the entitlements we haven't paid for. We are not talking about all the money we have raided out of Medicare and Social Security in order to pay for current expenses. Some people say those obligations are more than $60 trillion, numbers we can't even comprehend.

I filed this resolution. I will send a letter to every Governor asking them to adopt it in advance of the Congress taking it up. A constitutional amendment requires two-thirds of both Chambers and three-quarters of the States. They can act first. They can send letters and resolutions from their legislators to this legislative body and say: Get your act under control.

It affects them too. This new health care bill is going to send an unfunded mandate to the States and increase Medicaid from 100 percent of poverty to 133 percent. They will have to pay that bill. It is going to cost Florida in 10 years almost $1 billion. Right now, in Florida, the No. 1 expenditure in our budget is Medicaid. Because we balance our budget, that means we take money away from teachers and education. That means we take money away from law enforcement. It is out of control.

I am here to say the siren is sounding. The ship is going to hit the iceberg. We can't make just incremental change because then we will just hit the side of the iceberg. We have to make substantial change. The people in this body have to have the courage to do it. We can't just go along and get along as we have before. We cannot be tone deaf. The American people are onto us. They understand we are spending money we don't have. I will not stand by and let this great country fall into decline without at least arguing and pushing as strenuously as I can for a solution. I am willing to work with men and women of good will on both sides of the aisle to solve the problem. I am new here. I might not have all the answers. I probably don't. But I will surely work hard. I know this is one solution. If every State can have a balanced budget amendment and 43 States can have a line-item veto, why can't this body?

I have filed this resolution. I look forward to talking about it more. I hope this body will take it seriously. I see my friend from Massachusetts is here. He also is new to this body, although he spent many years working here. We have to do things differently. We throw around billions and trillions like it is just nickles and dimes in our pockets. It is not. Every dollar is a choice. It is a choice to make. If we don't make the right choice, it will be a choice our children and grandchildren will suffer under.

I yield the floor.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KIRK. Mr. President, ''The need for comprehensive national health insurance and concomitant changes in the organization and delivery of health care in the United States is the single most important issue of health policy today.'' Those are not my words. Those are the words of Senator Edward M. Kennedy. The ''today'' of which he spoke was December 16, 1969, exactly 40 years ago today. It was his first major speech on health care reform, and I was privileged to be a young member of his staff. He delivered that speech to a group of physicians at Boston University Medical Center.

Senator Kennedy went on to say:

If we are to reach our goal of bringing adequate health care to all our citizens, we must have full cooperation between Congress, the administration, and the health professionals. We already possess the knowledge and the technology to achieve our goal. All we need is the will. The challenge is enormous, but I am confident that we are all equal to the task.

The world has progressed in many ways since he spoke those words four decades ago, but our health care system has not. In 1969, the United States spent $18 billion on health care. Today we spend over $2 trillion a year. Senator Kennedy pointed out, in 1969, that the Nation faced a shortage of primary care doctors. The reimbursement rates for physicians treating Medicare and Medicaid patients were too low. There was a need to support greater innovation in delivering care, and neighborhood health centers were underfunded. He said we needed to develop an effective means of providing quality, affordable care to all Americans, regardless of their standing in life.

Does all this sound familiar? Yes. But that was then and this is now.

In recent weeks, Senators on both sides of the aisle have come to this floor to debate the merits of the Patient Protection and Affordable Care Act. We have had our differences of opinion, to be sure. But on one issue there is no dispute. When it comes to our health care system, there is no such thing as a status quo. We will move forward or we will continue to fall behind.

Here is what we will face, if we do not pass this reform. Premiums will skyrocket and could consume as much as 45 percent of a median family's income by 2016. Bankruptcies will increase due to families not being able to

afford their medical costs. More Americans will be uninsured. Small and large businesses will suffer financially due to health cost increases. Health care could constitute as much as 28 percent of our Nation's GDP by 2030. Fifteen percent of the Federal budget could be dedicated to Medicare and Medicaid by 2040.

Ted Kennedy had a keen sense of history. He knew Germany adopted the idea of national health insurance in the 1880s, that Britain, France, and a number of other European nations embraced the concept after the First World War, that Canada has had a publicly funded system since the 1950s. He would ask, as he did in 1969 and again in 2009: If all these nations understood long ago that their economic health was ultimately tied to the health of their people, why does the United States stand alone as the only major industrial nation in the world that fails to guarantee health care for all its citizens?

It is not that we have never sought this goal in the past. Presidents, Republicans and Democrats, over many decades, have proposed national health insurance in America. Presidents Theodore Roosevelt, Franklin Roosevelt, Harry Truman, John F. Kennedy, Richard Nixon, and Bill Clinton all made health reform a part of their agenda. Now we stand on the threshold of history. Never has this country been so close to bringing affordable, quality health care to millions of America's families. Today, under President Obama's leadership, the goal is within our reach. Failure is not an option. All interested parties have been brought to the table. Physicians, hospitals, insurance companies, small businesses, pharmaceutical companies, and many others have had an opportunity to present their suggestions and offer their input. Dozens of hearings were held on all topics related to this issue.

The House of Representatives has acted. The Senate HELP Committee, through the diligence of Senators Kennedy, DODD, and HARKIN and the Finance Committee, under the leadership of Senator BAUCUS, held lengthy executive sessions that discussed all areas of reform and delivered and developed their respective bills. Due to the hard work and tireless patience of the majority leader, we have one merged bill before us, a single piece of legislation which will improve the lives of millions of Americans in the following ways. It expands coverage to an additional 31 million Americans, bringing health insurance to almost 94 percent of our citizens. It saves money by rewarding the quality and value of care, not the quantity and volume of care. It controls the cost of skyrocketing premiums and limits out-of-pocket expenses. It reduces the Federal deficit by an estimated $130 billion in the first 10 years and an estimated $650 billion in the second 10 years. It stimulates competition in the health insurance marketplace through establishment of exchanges. It strengthens Medicare by reducing unnecessary spending, lowering prescription costs, and closing the so-called doughnut hole. It attacks fraudulent and wasteful spending and helps to correct abuses in the system. It rewards wellness and prevention by expanding access to advice on how to live a healthy lifestyle by practicing good nutrition, increasing physical activity, and quitting smoking.

It eliminates unfair discrimination against patients by preventing insurance firms from denying certain coverage to women or to individuals with preexisting conditions.

It promotes flexibility and innovation in new health care technologies. It introduces a self-funded, voluntary choice for long-term services and support for the elderly and disabled. Most of all, it saves lives by providing affordable, quality care for individuals, families, and small businesses.

In my State of Massachusetts, because of our successful reform, the rate of the uninsured has been reduced to 2.7 percent of the population, and the lives of thousands of citizens of our Commonwealth have been immeasurably improved.

Carol's case is one example. Carol did not realize the importance of having quality, affordable health insurance until she was confronted with the gravity of her own health problems. She is a 24-year-old woman suffering from seizures and desperately in need of help.

She remembers having occasional seizures as a child. They occurred mostly when she was overtired. As Carol grew older, the seizures became more frequent. One day, she had an episode when driving her car. Fortunately, her passenger was able to assist her. But that frightening incident convinced Carol to seek professional help.

She learned about the assistance of Health Care For All, the Massachusetts organization dedicated to making quality, affordable health care accessible to everyone. She applied and was declared eligible for Commonwealth Care. She immediately went to see a specialist and was given the health care she needed.

Carol expressed her gratitude in these words:

I definitely feel blessed to be a Massachusetts resident. I can't thank Health Care For All and MassHealth enough for all the support given to me. The Helpline counselors literally held my hands and brought me to live a healthy life, where there is no fear or embarrassment, but there is knowledge and a total control of my seizures. So, thank you so much all of you who make this happen in people's lives.

We should all think about Carol and the millions of working families across the country when we vote for this legislation. It is our responsibility to enact laws that make a positive difference in people's lives, and that is what this bill is all about.

Senator Ted Kennedy envisioned a better America where, as he said:

[E]very American—north, south, east, west, young, old—will have decent, quality health care as a fundamental right and not a privilege.

This is a historic moment in our national life. We have the chance to finally complete the work that a respected Republican President called for over a century ago. Quality health care for all has always been needed in America but never more than now. The finish line is clearly in sight. The momentum and the energy are with us, and it is our obligation to seize this historic moment.

Every Member of this body is aware of the valiant fight Senator Kennedy waged for his own health during the last 15 months of his life. Many of you saw him, after receiving radiation and chemotherapy in the morning in Boston, walk into this Chamber that he loved to cast a deciding vote in the afternoon on the issue he proudly called the cause of his life.

While being treated at Massachusetts General Hospital, Senator Kennedy met a woman named Karen List. Her daughter Emily was one of many patients receiving a similar regimen of exhausting cancer treatments. They came from different walks of life, and cancer had touched them all.

In September 2008, after Emily's long summer of treatments, Karen wrote about Senator Kennedy and other patients he had met during his treatment. She wrote:

Now, it is almost fall, and little Caroline is starting kindergarten. Senator Kennedy, who came from a hospital bed to speak at the convention, is planning his return to the Senate in January. Alex, an Apache helicopter pilot, is back at Fort Campbell and expects to be deployed to Afghanistan in the New Year. And Emily hopes to be well enough by spring to return to her life in London. The dream, as Senator Kennedy promised, does live on.

Mr. President, I ask unanimous consent that the article by Karen List in the Daily Hampshire Gazette be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

[From the Daily Hampshire Gazette, Sept. 8, 2008]

A CHAMPION OF HEALTH COMFORTS HIS FELLOW PATIENTS

(by Karen List)

As Sen. Ted Kennedy's distinctive voice passed the torch at the Democratic National Convention and promised us that the dream lives on, all I could think of was that same distinctive voice several weeks ago calling out: ''Where's Emily?''

Ted was at the other end of the hall in the Proton Therapy Center, Dept. of Radiation Oncology, at Massachusetts General Hospital, where both the senator and my daughter Emily were being treated for cancer.

The proton beam is cutting-edge treatment for certain types of tumors, and the MGH center is one of only five in the country and a handful in the world.

We were lucky to be there, though it was getting increasingly hard to feel lucky as seven weeks of daily treatment took their toll on Emily and the other patients at the center.

They ranged in age from toddlers to the elderly. Little Caroline was 5. Senator Kennedy was 77. In between them were Emily, 23,

and Alex, 26, two of just a few young adults in proton beam treatment.

Radiation burn was the worst side effect for many patients, and it was now preventing Emily from eating or talking. She was at a low point, and she needed a lift.

We had seen Teddy come and go for several days, slipping in through a side entrance and out the same way, always accompanied by his wife, Vicki. When our eyes happened to meet, we exchanged a thumb's up and were treated to that Kennedy smile—as distinctive as the voice.

The day before Ted's treatment was to end, Emily's nurse stopped by the room where she was being treated and pulled the curtain aside. Several minutes later we heard him call from the other end of the hallway: ''Where's Emily?'' And then he was there, talking to her, encouraging her—and just as quickly, he was gone.

Emily was so excited that she was hopping up and down in the bed from a reclining position, if such a thing is possible. But because she couldn't talk, she hadn't been able to say a word to one of the few politicians she really admires.

The next day, our nurse delivered the card we'd written to the senator, explaining how thrilled Emily had been to meet him and how distressed she was that she couldn't tell him so herself. On the card was a photo of Emily at her favorite English pub, smiling her own distinctive smile. She had been home for a short break from her work interning in the London Theater when she'd been diagnosed with cancer. Now she was battling to get her work and her life back.

Teddy had just finished his treatment. This time, as he came down the hall for the last time, Emily was ready. On the slate that she'd been using to communicate, she'd written in purple marker: ''We love you, Ted.'' The senator laughed, walked to her bedside and whispered to her for a few minutes in solidarity, while Vicki talked to Emily's dad and me. We exchanged heartfelt good wishes for each other as they left the center to return home.

Emily had another week of treatment left. During that time, her nurse told us how concerned Sen. Kennedy had been about the other patients, especially the children and young people—and their parents. He had been through this same experience with his own son decades earlier when only one type of chemotherapy was available, unlike the cocktail of diverse chemo drugs that patients like Emily receive today.

This lifelong champion of health care for all Americans, especially children, had experienced once again—this time as the patient himself—what first-rate cancer care could mean. And he intends to continue fighting for its accessibility to everyone as the senior Democrat on the Health, Education, Labor, and Pensions Committee.

On Emily's last day at the center, there was a special gift waiting for her. Ted had left her a copy of his book, ''My Senator and Me: A Dog's-Eye View of Washington, D.C.,'' written by him and his dog Splash. It was inscribed: ''To Emily—Splash and I hope you enjoy.''

And she did. Ted had provided just the encouragement she needed. He'd also left a stack of books for other young patients and the book on tape for those whose vision had been compromised by their treatments.

Now it's almost fall, and little Caroline is starting kindergarten. Senator Kennedy, who came from a hospital bed to speak at the convention, is planning his return to the Senate in January. Alex, an Apache helicopter pilot, is back at Ft. Campbell and expects to be deployed to Afghanistan in the New Year. And Emily hopes to be well enough by spring to return to her life in London.

The dream, as Senator Kennedy promised, does live on.

Mr. KIRK. Karen's was a statement of hope—hope and promise for each of these patients in the face of daunting odds. Their age did not matter; their economic status did not matter; each received the highest quality of health care available. And so it should be for all our people.

Senator Kennedy understood that we are all connected to one another. He often referred to President Lincoln's words about our common humanity and the good that can come to us all when touched ''by the better angels of our nature.'' And he knew that on no issue are our futures more connected than on health care.

Ted Kennedy's voice still echoes in this Chamber. His spirit of hope and strength, of determination and perseverance is still felt here. He said:

For all my years in public life, I have believed that America must sail toward the shores of liberty and justice for all. There is no end to that journey, only the next great voyage. We know the future will outlast all of us, but I believe that all of us will live on in the future we make.

Let each of us in this Senate be moved by the better angels of our nature and make that future a better one for our generation and for generations to come. As Ted Kennedy said 40 years ago: ''All we need is the will.'' This is our time, Mr. President. Let us pass this legislation now.

Mr. President, I ask unanimous consent that the speech delivered by Senator Edward M. Kennedy on December 16, 1969, be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

ADDRESS BY SENATOR EDWARD M. KENNEDY, LOWELL LECTURE SERIES, BOSTON UNIVERSITY MEDICAL CENTER—LOWELL INSTITUTE, DECEMBER 16, 1969

I am delighted to be in Boston today under the auspices of the Boston University Medical Center and the Lowell Institute to address this distinguished audience of medical educators, private physicians, and lay men concerned with the quality of health care in America.

I am particularly pleased to be here because it gives me the opportunity to commend the many worthy accomplishments of the Boston University Medical Center and its School of Medicine. You have succeeded in breaking down walls that for decades have turned medicine inward toward the age-old trinity of patient care, research and teaching. You have expanded your horizon to embrace the equally important area beyond your walls—the community in which we live.

For more than 90 years, your Home Medical Service has taken students into the community and provided model health care and innovative medical services in the home. Your expanding programs of new hospital affiliation have brought modern urban medicine to outlying communities. You have helped to lead the way in efforts throughout the world to unify cancer care with cancer research, so that today's advances in the laboratory become tomorrow's accepted treatment. Your School of Graduate Dentistry, dedicated in September, will provide high quality dental care as part of the Medical Center's total health program for the community.

In the course of the past decade, your pioneering program in community psychiatry and mental health in the South End and Roxbury—launched long before the Great Society and the Office of Economic Opportunity came into being and made such programs fashionable—have become a model for the nation. You helped develop what is now the rallying cry for health planning in America—that new health programs must be designed with the people and by the people, not just for the people. As Dr. Handler has so eloquently stated, your far-reaching role in community involvement is like a man standing by a river watching people drown:

''Medicine traditionally wades in,'' he said, ''and tries to save them one at a time. After doing this repeatedly, you can't help but ask what is happening upstream. It seemed sensible to go back and find out why all the people were falling in, and try to do something about it.''

I commend you for your leadership in looking upstream, and for the remarkable efforts you are making in preventive community medicine and all the other major areas of this great center's activity.

Six weeks ago in Springfield, I had the occasion to discuss what I regard as the single overriding economic issue of the day—the war against inflation. As I have frequently stated, the war against inflation is a war that can and must be won without the cost of heavy unemployment. It is a war that can and must be won without cutting back on our important domestic priorities.

Nowhere is the impact of inflation more obvious than in the rising cost of medical care. Never has the gift of good health been more precious:

In the last three years, the cost of health has risen by 22 per cent, or nearly double the rise in general consumer prices.

Hospital daily service charges have soared by the astronomical rate of 55 per cent, or nearly five times the rise in consumer prices. The average cost of a hospital day is now $68. It will rise to $74 next year, and to $98 by 1973.

Physicians' fees have risen by 21 per cent. Doctors line up at lawyers' offices to form corporations and raid the Federal Treasury for hundreds of thousands of dollars a year in deferred taxes.

All of this inflation has occurred during the early years of Medicare and the troubled Medicaid program. The most rewarding experience of Medicare has been its success in solving the serious problem of health costs for our poor and our aged citizens. In spite of inflation, Medicare has been immensely popular. It is liked and accepted by the people.

The most painful experience of Medicare and Medicaid has been their unfulfilled promise. We sought to spread the benefits of medical science and technology to millions of Americans, without considering the anachronistic and obsolete structure of the system by which the health services would be delivered. Unwisely, as many experts have recognized, we assumed that all that stood between our poor and aged citizens and high quality medical care was a money ticket into the mainstream of modern American medicine.

We know now that we were wrong. The money ticket was important, but it was not enough to solve the problem. In the years since Medicare and Medicaid were enacted, we have learned that medical insurance and payment programs could not be translated instantaneously into more doctors, more nurses, more health facilities, or better organization of the delivery system.

In wedding new purchasing power to the already existing demand for health services, we did nothing to solve an already intolerable situation. The cost of health care began

to soar. In some cases, the quality of care declined, and an enormous strain was placed on the capacity of our existing health services and facilities. When an already overworked physician goes from seeing one hundred patients a day to seeing two hundred patients a day, the quality of his care is inevitably affected. His only escape is to consign more of his patients to hospital treatment, thereby increasing the strain on hospital facilities and hospital costs.

Today in the United States, health care is big business. Indeed, it is the fastest growing failing business in the nation—a $60 billion industry that fails to meet the urgent demands of our people. Today, more than ever before, we are spending more on health care and enjoying it less. By 1975, we may be spending $100 billion a year on health and be worse off than we are now in terms of the quality and responsiveness of our health care system.

Perhaps the most serious fault in the present situation is the failure of the Federal Government to play a greater role in improving the quality of the nation's health care. Health is big business in America, and the Federal Government has become a major partner in this business. The total outlays for medical and health-related activities in the Federal budget estimated for 1970 are $18 billion, or nearly one-third of the total health expenditures in the nation. The outlays for 1970 are divided among 14 principal departments and agencies. By far the largest amount—$13 billion—is expended by the Department of Health, Education and Welfare, but significant amounts are also expended by the Department of Defense—$2 billion—and the Veterans Administration—$1.7 billion.

In 1960, the total outlays for health in the Federal budget were only $3 billion. Thus, in the decade of the Sixties alone, we have had a six-fold increase in total Federal outlays for health. Indeed, almost 10 per cent of the total Federal budget now goes for health. The major share of the rise in recent years has been for Medicare and Medicaid. Yet, in spite of the dramatic increases in the health budget and the large amounts we are now spending, there is almost no one who believes that either the Federal Government or the private citizen is getting full value for his health dollar.

Of course, a significant proportion of the increase in health expenditures is being consumed by rising costs and our growing population. Between 1950 and 1969, personal health care expenditures increased by $42 billion. Of this increase, 50 per cent was attributable to rising coats, and another 19 per cent was attributable to population growth, so that only 31 per cent of the increase represents real growth in health supplies and services over the past two decades.

Although the conventional wisdom is content to blame our current medical inflation on Medicare and Medicaid and the excess demand created by these programs for health care, there is another, more controversial aspect to the rising prices. At Professor Rashi Fein and other experts in the field of the economics of medicine have made clear, the basic models used by economists are not appropriate when applied to health. The medical market. is characterized by the absence of competition, diverse products, and consumer ignorance. Comparisons of quality and performance are extremely difficult, if not impossible.

In other words, the medical marketplace is an area where the laws of supply and demand do not operate cleanly, and where physicians have a relatively large amount of discretion in setting their fees. Thus, at the time Medicaid and Medicare were instituted, fees rose for a variety of reasons, many of which were unrelated to the creation of excess demand:

Some physicians raised their fees in anticipation of a Federal fee freeze.

Some raised their fees in the face of rising hospital costs, in order simply to preserve their slice of the growing health pie.

Some raised their fees simply because they had the discretion to do so, and decided to take advantage of the instability and price consciousness generated by the new Federal programs.

As In the case of physicians' fees, the economic model of supply and demand does not tell the whole story of rising hospital costs. In part, hospitals took the opportunity to provide substantial—and wholly justified—wage and salary increases to their notoriously underpaid employees. In part, costs rose because the new Federal financing methods contained few incentives for improving efficiency, but simply encouraged hospitals to pass the higher costs on to Washington.

The high cost of medical care is but one aspect of the overall health crisis, In America today, it is clear that we are facing a critical shortage of health manpower. Indeed, at bottom, our crisis in medicine is essentially a crisis in manpower. The need is urgent for more physicians, more dentists, more nurses, and more allied health professional and technical workers. We must develop new types of health professionals and pare-professionals. We must make far more efficient utilization of our existing health manpower. Only if we succeed in these efforts will we be able to free our physicians and highly trained medical experts to perform the sort of intricate operations and sensitive counselling discussed by Dean Redlich in the inaugural lecture in this series.

The need is especially clear in the case of the shortage of doctors. Our low physician-population ratio means that unsatisfactory medical care is a way of life for large numbers of our people in many parts of our nation. In 1967, in the United States as a whole, there were 260,000 private physicians providing patient care for our 200 million people. This is a ratio of 130 physicians for every 100,000 citizens, or one doctor for every 700 people.

At first glance, the ratio appears to be fairly close to the satisfactory ratio generally recommended by many health experts, but the figures are misleading. The family doctor—the general practitioner—is fast disappearing, and is on the verge of becoming an extinct species. At the present time only one out of four of the nation's physicians is engaged in the general practice of medicine. Three out of four are specialists, most of whom accept patients only on a referral basis. The true doctor-population ratio, therefore, is more like one general practitioner per three thousand population, a ratio that is clearly unacceptable for adequate health care for our people. For far too many of our citizens, the only ''doctor'' they know is the cold and impersonal emergency ward of the municipal hospital.

To make matters worse, the geographic distribution of our doctors is highly uneven. Two-thirds of our physicians serve the more affluent half of our population. In some states, of course, the physician-population ratio is higher than the national average of 130 doctors per 100,000 population. In Washington, D.C., the ratio is 318; in New York it is 199; in Massachusetts, 181.

In sixteen states, however, the physician-population ratio is far below the national average. In Alaska and Mississippi, the ratio is an abysmal 69, or about one-half the national average. In Alabama, it is 75. Even in Texas, it is only 106. Clearly, therefore, extremely large groups of our population are receiving seriously inadequate medical care because of the shortage of physicians.

One of our most urgent needs to meet this crisis is a stronger Federal program to expand existing medical schools and establish new schools. We must substantially increase the output of doctors from our medical schools. At the present time, about 8,000 students are graduated from our medical schools each year. The Association of American Medical Colleges estimates that the number of students entering medical schools will increase by 25 per cent to 50 per cent by 1975, as a result of the construction of new medical schools already begun, and the expansion of existing schools already planned. Yet, if the physician-patient ratio is to be improved substantially, our goal should be to admit double the number of current students by 1975, with special emphasis on medical schools in regions where the physicians-population ratio is too low.

There is another reason why we must increase the enrollment in our medical schools, aside from the need to provide better health care for our people. Today in America, the medical profession is that one profession that flies in the face of the American credo that every man shall have the opportunity to join the profession of his choice. Today in America, if a poor black or white young American aspires to be a lawyer, he will have the opportunity to enroll in a law school somewhere in the nation that will give him the chance to fulfill his dream. It is the shame of American medicine that no such opportunity exists for the youngster who aspires to enter what is perhaps the most exalted and selfless of all our professions, the healing arts.

Ironically, at the very time we are denying this opportunity to our own citizens, we are importing thousands of foreign-trained doctors each year to meet our manpower crisis. Twenty per cent of the newly licensed physicians each year in the United States are foreign-trained. Forty thousand foreign medical graduates are now practicing medicine in the United States, or about 15 per cent of the total number of doctors providing patient care. Thirty per cent of all our interns and residents are foreign-trained.

These figures are appalling. I believe that at this crucial period in world history, it is deeply immoral for us to be luring physicians from the rest of the world to meet our own doctor shortage, when their services are even more critically needed in their own lands.

The landscape we see is bleak, but it is not without hope. If we are to be equal to the challenge, however, we must be prepared to take major new steps. As Hippocrates himself put it two thousand years ago, where the illness is extreme, extreme treatments may be necessary. I would like, therefore, to share with you my views as to the directions we should begin to take now, if we are to meet the challenge.

First, and perhaps most important, we need a new approach to the politics of health. Our single greatest deficiency in the area of health is our failure to develop a national constituency, committed to a progressive and enlightened health policy. As a prestigious Committee of the National Academy of Sciences has recently and eloquently stated with respect to the problem of the confrontation between technology and society, the issue is far more serious than the simple question of braking the momentum of the status quo. Today, all too often, whether the area be that of medicine, or education, or pollution, the vested interests are strongly ranged against innovation, and there is no champion capable of marshaling the diffuse advocates for progress and reform. When a better teaching organization threatens the bureaucratic status quo in education, we know there will be organized opposition from

school officials, but there is seldom organized advocacy by parents and children. When a new and more efficient development is offered that threatens the status quo in health—whether in the organization, financing, or delivery of health care—we know there will be opposition from organized medicine, but there is seldom organized advocacy by health consumers.

In these situations, a thorough consideration of the relative merits of alternative proposals is rendered difficult, if not impossible, by the presence of powerful spokesmen for the old, and the absence of effective spokesmen for the new. If we are to succeed in making basic changes in our health care system, we can do so only by creating the sort of progressive national health constituency that can make itself heard in the halls of Congress and the councils of organized medicine.

To be sure, there is cause for hope. The present generation of medical students is outstanding. They are already beginning to develop the commitments to public causes, the enlightment and social conscience so desperately needed in the health profession, And, in spite of the heavy responsibility that organized medicine must bear for the inadequacy of our health manpower and other resources, a few leaders have recently made progressive statements suggesting a new recognition and awareness of the problem.

Second, the Federal Government must play a far more active and coherent role in the formulation and implementation of health policy. We must develop a comprehensive and carefully coordinated national health policy, with an administrative structure capable of setting health goals and priorities for the nation, In the spring of 1968, I introduced legislation urging the creation of a National Health Council to be established in the Executive Office of the President with responsibility for setting health policies and making recommendations for the attainment of health goals, including the evaluation, coordination, and consolidation of all Federal health programs and activities. The National Health Council would be modeled along the lines of the Council of Economic Advisors, which has consistently played a superlative role in planning and coordinating the nation's economic policy.

Third, we must move away from our excessive emphasis on high-cost acute-care hospital facilities. We must make more imaginative use of innovative types of low-cost facilities, such as neighborhood health centers and other out-patient facilities, storefront clinics, and group health facilities. In spite of the active opposition of a substantial segment of the medical profession, group practice and hospital-based practice are probably the most efficient and economical means of delivering health care today. In many areas, the ideal arrangement consists of a teaching hospital in a medical center, with affiliations to community hospitals in the surrounding area. In turn, each of the community hospitals serves as the center of a series of satellite group practice clinics that can reach out directly into the entire community.

Fourth, while we are building the nation's overall health policy, we must give special attention to the health of our urban and rural poor. For too many of the poor, the family physician has disappeared, to be replaced by the endless lines and impersonal waiting rooms of huge municipal and county hospitals. Yet, there are few physicians today who were not trained on the wards and charity patients in our teaching hospitals. Too often, as Professor Alonzo Yerby has eloquently stated, our poor have had to barter their bodies and their dignity in return for medical treatment.

In America today, millions of our citizens are sick, and they are sick only because they are poor. We know that illness is twice as frequent among the poor. We know that the poor suffer three times as much heart disease, seven times as many eye defects, five times as much mental retardation and nervous disorders. Although our goal must be one health care system open to all our citizens, we have an obligation now to increase the range and efficiency of the health services and facilities available to the poor, with special emphasis on breaking down the barriers that have for so long divided our society into a two-class system of care—one for the rich and one for the poor, separate and unequal.

Specifically, I urge the Administration to create a National Health Corps, as an alternative to the draft for doctors, and stronger than the ''Project U.S.A.'' program recently recommended by the AMA. Today, doctors are exempt from the draft if they serve two years in the National Institutes of Health or other branches of the Public Health Service. The same exemption should exist for doctors volunteering for medical service in urban or rural poverty areas, Only in this way will we be able to meet the critical need for health manpower in depressed areas. And, once young physicians are exposed to the problems of health care for the poor, a significant proportion of them will be encouraged to remain and dedicate their careers to this service.

In addition, we should make a substantial new effort to expand the neighborhood health center program. At the present time, less than a dozen medical societies in the nation have become actively involved in neighborhood health centers. Yet, in recent weeks, prominent leaders of the AMA itself have called for a greater role for neighborhood health centers as a means of extending health care to the poor. A few imaginative pilot projects reaching in this direction have recently been funded by the Office of Economic Opportunity, including a program to reorganize the out-patient department at Boston City Hospital as a nucleus for community health care, but our overall effort has been inadequate. Tragically, at a time when even organized medicine is moving forward, we have been unwilling to allocate the resources so urgently needed for this program.

Fifth, within the critical area of health manpower, we must give special attention to training new types of health professionals. In far too many cases, highly trained physicians spend the overwhelming majority of their working day in tasks that do not require their specialized medical skills. One of the most promising methods of easing the shortage of doctors is to train new types of health workers to perform these non-specialized tasks, thereby freeing our physicians for other, more urgent needs. We must develop a broad new range of allied health professionals, such as paramedical aides, pediatric assistants, community service health officers, and family health workers.

At a number of our universities, imaginative new programs are under way to train medical corpsmen from Vietnam as physicians' assistants. In the State of Washington, hospital corpsmen are trained for three months in the medical school, and then sent into the field for nine months' further training in the offices of private physicians. A similar program now exists at Duke University. These programs are unique in their emphasis on combined training in the classroom and in the field. They are programs that must be greatly expanded if we are to meet the urgent demand for more and better trained health manpower.

Sixth, we must restore the severe budget cuts that have been proposed in Federal health programs by the present Administration. Later this week, the full Senate will vote on Federal health appropriations for the current fiscal year, 1970. None of us in Congress can be proud that almost half way through the present fiscal year, we are only now about to vote the funds that may be used. Our error is compounded by the knowledge that at this time of medical crisis, Federal assistance to health programs may be drastically curtailed, especially in the areas of research and manpower training.

Today, when every medical school and every other health school is being urged to expand its manpower programs, the Administration is requesting far less funds than Congress authorized as recently as 1968 for these vital programs.

The impact of the proposed cuts will be felt in medical schools, hospitals, research centers, and communities throughout the nation. It will be measured in terms of cancer research cut short, lives lost because coronary care units are un-funded, special hardship for the poor, and the loss of dedicated young students from careers in medicine and medical research.

Seventh, I come to what I believe is the most significant health principle that we as a nation must pursue in the decade of the Seventies. We must begin to move now to establish a comprehensive national health insurance program, capable of bringing the same amount and high quality of health care to every man, woman, and child in the United States.

National health insurance is an idea whose time has been long in coming. More than a millennium ago, Aristotle defined the importance of health in a democratic society, when he said:

''If we believe that men have any personal rights at all as human beings, then they have an absolute moral right to such a measure of good health as society and society alone is able to give them.''

Today, the United States is the only major industrial nation in the world that does not have a national health service or a program of national health insurance. The first comprehensive compulsory national health insurance was enacted in Prussia in 1854. Throughout the Twentieth century, proposals have been periodically raised for an American program, but never, until recently, with great chance of success.

National health insurance was a major proposal of Theodore Roosevelt during his campaign for the Presidency in 1912. Shortly before the First World War, a similar proposal managed to gain the support of the American Medical Association, whose orientation then was far different than it is today, During the debate on social security in the Thirties, the issue was again raised, but without success.

Today, the prospect is better. In large part it is better because of the popularity of Medicare and the fact that many other great national health programs have been successfully launched. The need for national health insurance has become more compelling, and its absence is more conspicuous. In part, the prospect is good because the popular demand for change in our existing health system is consolidating urgent and widespread new support for a national health insurance program as a way out of the present crisis.

For more than a year, I have been privileged to serve as a member of the Committee for National Health Insurance, founded by Walter Reuther, whose goal has been to mobilize broad public support for a national health insurance program in the United States. Two months ago in New York City, the Reuther Committee sponsored a major conference, attended by officers and representatives of more than 65 national organizations, to consider a tentative blueprint for

a national health insurance program. At the time of the conference, I commended Mr. Reuther for the extraordinary progress his Committee has made. I look forward to the future development of the program. Already, it offers. one of the most attractive legislative proposals that is likely to be presented for our consideration next year in Congress.

We must recognize, therefore, that a great deal of solid groundwork has already been laid toward establishing a national health insurance program. It is for this reason that I believe it is time to transfer the debate from the halls of the universities and the offices of professors to the public arena—to the hearing rooms of Congress and to the offices of your elected representatives.

Early next year, at the beginning of the second session of the 91st Congress, I intend to introduce legislation proposing the sort of comprehensive national health insurance legislation that I believe is most appropriate at the current stage of our thinking. The mandate of the Medicaid Task Force in the Department of Health, Education and Welfare has been expanded to investigate this area, and I urge the Administration to prepare and submit its own proposals.

Senator Ralph Yarborough of Texas has told me that, as Chairman of the Senate Subcommittee on Health, he will schedule comprehensive hearings next year on national health insurance. Our immediate goal should be the enactment of legislation laying the cornerstone for a comprehensive health insurance program before the adjournment of the 91st Congress. This is an issue we can and must take to the people. We can achieve our goal only through the mobilization of millions of decent Americans, concerned with the high cost and inadequate organization and delivery of health care in the nation.

Last week on the floor of the Senate, we witnessed the culmination of what has been one of the most powerful nationwide legislative reform movements since I joined the Senate—the taxpayers' revolution. It now appears likely that by the end of this month, there will be laid on the President's desk the best and most comprehensive tax reform bill in the history of the Federal income tax, a bill that goes far toward producing a more equitable tax system.

We need the same sort of national effort for health—we need a national health revolution, a revolution by the consumers of health care that will stimulate action by Congress and produce a more equitable health system.

Because of the substantial groundwork already laid, I believe that we can agree on three principles we should pursue in preparing an effective program for national health insurance:

First, and most important, our guiding principle should be that the amount and quality of medical care an individual receives is not a function of his income. There should be no difference between health care for the suburbs and health care for the ghetto, between health care for the rich and health care for the poor.

Second, the program should be as broad and as comprehensive as possible, with the maximum free choice available to each health consumer in selecting the care he receives.

Third, the costs of the program should be borne on a progressive basis related to the income level of those who participate in the program.

I believe there is no need now to lock ourselves into a specific method of financing the insurance program. There are distinct advantages and disadvantages to each of the obvious alternative financing methods that have been proposed—financing out of general revenues of the Treasury, out of tax credits, out of the Social Security Trust Fund, or out of another independent trust fund that could be created specifically for the purpose.

At the present time, I lean toward a method of financing that would be based on general Treasury revenues, with sufficient guarantees to avoid the vagaries of the appropriations process that have plagued the Congress so much in recent years.

I recognize the obvious merit of the tax credit and social security approaches. In particular, Social Security financing offers the important advantage that it is a mechanism that Americans know and trust. In the thirty-five years of its existence, Social Security has grown into a program that has the abiding respect and affection of hundreds of millions of Americans. In 1966, it demonstrated its capacity to broaden its horizon by its successful implementation of the Medicare program. To many, therefore, Social Security is the obvious vehicle to embrace a program for national health insurance, and soothe the doubts and suspicions that will inevitably besiege the program when it is launched.

At the same time, however, we must recognize the obvious disadvantages of Social Security financing. Under the Social Security system, the payroll tax is heavily regressive. The poor pay far too high a proportion of their income to Social Security than our middle or upper income citizens. Today, at a time when Congress is about to grant major new tax relief to all income groups, I believe it would be especially inappropriate to finance a national health insurance program through the conventional but regressive procedures of Social Security, rather than through the progressive procedures of the Federal income tax laws.

I wish to make clear, however, that I am not now rejecting an approach that would finance national health insurance by a modified approach through the Social Security System. By the use of payroll tax exemptions and appropriate contributions from the Federal. Government, it may be possible to construct a program that will build in the sort of progression that all Americans can accept. The important point here is that we must discuss these possibilities in a national forum, and weigh the alternatives in the critical light of open hearings and national debate.

We must be candid about the costs of national health insurance. In light of our present budgetary restrictions, the price tags applied to the various health insurance programs are too high. They range from about $10 billion for ''Medicredit,'' the AMA proposal, to about $40 billion for the Reuther proposal, It is therefore unrealistic to suppose that a total comprehensive program can be implemented all at once.

We can all agree, however, that it is time to begin. In light of the fiscal reality, the most satisfactory approach is to set a goal for full implementation of the program at the earliest opportunity. I believe that the goal should be 1975. The legislation we enact should reflect our firm commitment to this target date. Halfway through the decade of the Seventies, we should have a comprehensive national health insurance, program in full operation for all Americans.

I have already stated my view that legislation establishing the program should be enacted next year. In January, 1971, we should begin to phase-in a program that will reach out to all Americans by the end of 1975, To meet that timetable, we should establish coverage in the first year—1971—for all infants, pre-school children, and adolescents in elementary and secondary schools. In each of the following four years, we should expand the coverage by approximately ten-year age groups, so that by the end of 1975, all persons up to age 85 will be covered by the program, and the existing Medicare program can be phased in completely with the new comprehensive insurance.

The idea of phasing in children first should receive wide support, both from the population as a whole and from the medical profession as well. As a nation today, the United States is the wealthiest and most highly developed medical society in the world, but we rank 14th among the major industrial nations in the rate of infant mortality, and 12th in the percentage of mothers who die in childbirth. In spite of our wealth and technology, we have tolerated disease and illhealth in generations of our children. We have failed to eliminate the excessive toll of their sickness, retardation, disability and death.

Equally important, we are already close to the level of manpower needed to implement a national health insurance program for our youth. American medicine is equal to the challenge. We have a solid tradition of excellence in pediatric training, with a strong and growing supply of experienced pediatricians, pediatric nurses, and allied manpower.

Moreover, by beginning our new program with youth and child care, it will be easier for the medical profession to implement the changes in the delivery system that must accompany any effective national health insurance program. And, the changes that we make in the delivery system for pediatric care will give us valuable experience and insights into the comparable but far more difficult changes that will be necessary in the delivery of care to adults as the insurance program is phased in over subsequent years.

Finally, by phasing in the insurance program over a period of years, I believe we can avoid a serious objection that will otherwise be raised—that national health insurance will simply exacerbate our current inflation in medical costs by producing even greater demand for medical care without providing essential changes in the organization and delivery system.

We know from recent experience that changes in the organization and delivery of health care in the United States will come only by an excruciating national effort. Throughout our society today, there is perhaps no institution more resistant to change than the organized medical profession. Indeed, because the crisis is so serious in the organization and delivery of health care, there are many who argue that we must make improvements here first, before we can safely embark on national health insurance.

I believe the opposite is true. The fact that the time has come for national health insurance makes it all the more urgent to pour new resources into remaking our present system. The organization and delivery of health care is so obviously inadequate to meet our current health crisis that only the catalyst of national health insurance will be able to produce the sort of basic revolution that is needed if we are to escape the twin evils of a national health disaster or the Federalization of health care in the Seventies. To those who say that national health insurance won't work unless we first have an enormous increase in health manpower and health facilities and a revolution in the delivery of health care, I reply that until we begin moving toward national health insurance, neither Congress nor the medical profession will ever take the basic steps that are essential to reorganize the system. Without national health insurance to galvanize us into action, I fear that we will simply continue to patch the present system beyond any reasonable hope of survival.

The need for comprehensive national health insurance and concomitant changes in the organization and delivery of health

care in the United States is the single most Important issue of health policy today. If we are to reach our goal of bringing adequate health care to all our citizens, we must have full and generous cooperation between Congress, the Administration, and the health profession. We already possess the knowledge and the technology to achieve our goal. All we need is the will. The challenge is enormous, but I am confident that we are equal to the task.

Mr. KIRK. Mr. President, I yield the floor.

Mr. President, I suggest the absence of a quorum and ask unanimous consent that the time in the quorum call be divided equally between the majority and minority.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. JOHNSON. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. JOHNSON. Mr. President, I rise to express my support for the Patient Protection and Affordable Care Act and to encourage my colleagues to support this effort to address our health care system's immediate and long-term challenges in a fiscally responsible manner.

For decades, attempts have been made to reform the way our health care system works, but only incremental changes have been made. The result is a broken system where costs are rising out of control and millions of Americans are priced out of the health insurance market.

In the last 8 years, health care premiums have grown four times faster than wages. If health care costs continue to rise at the current rates, without reform, it is projected that the average South Dakota family will be paying nearly $17,000 in yearly premiums by 2016. That is a 74-percent increase over the current premium costs that so many already struggle to afford.

Throughout the ongoing health reform discussion, I have heard from far too many South Dakotans who currently face barriers in accessing quality health care. This can be due to exorbitant out-of-pocket costs, having no insurance coverage, being denied coverage by insurance companies, or limited or no health care providers in their area. The Patient Protection and Affordable Care Act addresses these barriers in part by extending access to affordable and meaningful health insurance to all Americans.

This legislation stands up on behalf of the American people and puts an end to insurance industry abuses that have denied coverage to hard-working Americans when they need it most. Insurance companies will no longer be able to deny coverage for preexisting conditions and will not be able to drop coverage just because a patient gets sick. Reform will ensure that families always have guaranteed choices of quality, affordable health insurance whether they lose their job, switch jobs, move, or get sick.

The bill allows Americans to shop for the best health care plan to meet their needs and provides tax credits to help those who need assistance. It strengthens our health care workforce, improves the quality of care, and reduces waste, fraud, and abuse in the health care system.

Every American is adversely affected in some fashion by the shortcomings of our existing system, and far too many have a false sense of security. The system costs us lives, and it costs us money. If we fail to act, health care costs will consume a greater and greater share of our Nation's economy and have tremendous potential to cripple our Nation's future.

The Patient Protection and Affordable Care Act puts our Nation on a more sustainable financial path. The nonpartisan Congressional Budget Office projects that this health reform bill will reduce the Federal deficit by $130 billion in the next 10 years and as much as $650 billion in the decade after that. CBO also projects that this bill will result in health care coverage for more than 94 percent of legal residents in our Nation. Our citizens deserve this basic security, while improving current Medicare benefits.

This bill is the product of months of research, committee deliberation, and bipartisan negotiation. I have listened to some of my colleagues' claims that they support health reform yet object to this approach. These protests echo those made nearly 50 years ago when a new program called Medicare was proposed to provide meaningful health benefits to seniors. The increasing cost of health care is unsustainable and the do-nothing approach hurts all Americans by robbing us of this historic opportunity to stop talking about the problems and finally find a solution.

This bill is not perfect, but a ''yes'' vote will allow the conference committee a chance to improve it. The United States is the only Nation among industrialized democracies to not have some form of national health care. Yet the Senate Republican Party is attempting to deny us the right to vote this historic legislation up or down. They want to kill it even before it has the chance to go to conference.

I urge my colleagues to support the Patient Protection and Affordable Care Act.

Mr. President, I ask unanimous consent that the time be charged equally.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The Senator from Ohio is recognized.

Mr. VOINOVICH. Thank you, Mr. President. I have been coming to the floor to remind my colleagues and the American people about the fiscal realities our Nation faces and to explain how this health reform legislation would make our fiscal situation worse and our economy suffer even more. I have been here before to highlight how this health care bill is chock-full of budget gimmicks to hide its true unmanageable costs.

As I have said before on the floor of the Senate, as a former mayor and a former Governor, many people have come to me over the years and said: Mayor, you have to do this; Governor, you have to do this. The plea they had was genuine, and the need they expressed was genuine, but the fact is we couldn't afford what they were asking us to do, and I had to say no. Unfortunately, this legislation, in my opinion, will increase the cost of health care, drive up our national debt, and contribute to unbalanced budgets as far as the eye can see in the United States.

As a former Governor and chairman of the National Governors Association, the past chairman of the National League of Cities, one gimmick I am particularly concerned about is the one that puts 14 million additional individuals into the Medicaid Program and then asks the States to pick up a portion of the tab. I am very familiar with what unfunded mandates can do to State and local governments, and I wish to highlight some of the potential consequences of the Medicaid expansion for my colleagues.

At a $374 billion cost to Federal taxpayers, the health care bill before us would expand Medicaid coverage to all people under 133 percent of the Federal poverty level. Because Medicaid costs are shared by the Federal and State governments, the States will be on the hook for $25 billion of this expansion during the first 10 years.

To put the $25 billion into perspective, let me spend a minute explaining the current fiscal situation of most States in this country. Most States such as my State—and I am sure the same is true in the Presiding Officer's State—are struggling to make ends meet. I have never seen anything like it in my entire life.

According to the National Governors Association, the States are in the deepest and longest economic downturn since the Great Depression. In the first two quarters of 2009, State revenues were down 11.7 and 16.6 percent, respectively. At the same time, Medicaid spending is growing, which already makes up, on average, approximately 22 percent of States' budgets, and enrollment in the program is skyrocketing at the levels it is today because more and more people are becoming eligible for Medicaid under the current Federal law.

In Ohio, for example, where the unemployment rate is hovering around 10.5 percent, 154,000 Ohioans enrolled in the Medicaid Program in the last year alone, an 8-percent increase over last year. This is hard to believe, but Medicaid now provides health coverage to nearly 2 million Ohioans, almost one out of five residents. Unbelievable.

Recognizing this increased demand, States have had some help from the Federal Government. Earlier this year,

Congress provided $87 billion in Federal aid to States in the so-called stimulus bill to help States deal with Medicaid costs. Yet this money was not intended to last forever. As it stands right now, in December 2010, States will face—that is next December—States will face a steep budget cliff when the temporary Medicaid payments coming from the stimulus package expire. In facing these realities, Governors across the country are already wondering how they will cover the cost of their existing programs.

I recently met with Ray Scheppach, who is the executive director of the National Governors Association. He said: Senator, Governor, Mayor, we are going to need some help when the money runs out or we will not be able to handle the Medicaid challenges we have.

Not surprisingly, my State's current Governor, Ted Strickland, a Democrat, has told me if Medicaid is expanded, he hopes the Federal Government will assume most, if not all, the costs. In fact, he told the Columbus Dispatch that he has warned officials in Washington that ''with our financial challenges right now, we are not in a position to accept additional Medicaid responsibilities.''

I suspect that almost every Governor in the country would make that same statement to us in the Senate. By the way, this is both Republican and Democratic Governors.

I ask: How can we in good conscience move forward with this bill and the new mandate it places on States? How can we force the States to make the difficult choices that we are unwilling or unable to make in Washington? Pass it on to them, we will pay for it a while, and then you guys pick up the cost.

I served the people of Ohio as Governor for 8 years, and I was forced to cut my budget in the beginning four times. I will never forget it. There were about 5,000 people outside my office screaming because we had made it more difficult or increased the cost of tuition for our colleges. I had to make countless difficult decisions across the board to be fiscally responsible. I understand the demands of soaring health care costs, and as I called that program then, it devoured—Medicaid devoured up to 30 percent of our State budget, and I referred to it as the Medicaid Pac-Man. I think some people remember Pac-Man. That was the Pac-Man just eating up money like crazy. It took away money from primary and secondary education, higher education, roads, bridges, county and local government projects, and safety service programs that we wanted to provide for the citizens of Ohio. We had to do it. It was a mandate. It just sucked up that money, and that meant we didn't have money for higher education, secondary and primary education, and some of the other responsibilities of the State.

With this experience, I became particularly concerned with the cost of Federal mandates, and I worked tirelessly with State and local governments to help pass the Unfunded Mandates Reform Act. In fact, the first time I ever set foot on the floor of the Senate is the day the unfunded mandates bill passed the Senate. It was a wonderful day for Ohio and for this country. I was in the Rose Garden representing State and local governments when President Clinton signed the legislation into law in 1995.

After that experience, you can imagine how it pains me to be standing here today debating legislation that provides for the largest single expansion of the Medicaid Program in our country's history and a brandnew fiscal liability for States at a time when the States can least afford it. I have serious concerns if this bill becomes law and States are required to take on more just as the extra stimulus funds disappear—which they are going to have to do or we will have to come up with the money—Congress will be forced to spend billions more to keep the Medicaid safety net from failing completely in the not too distant future.

So what I am basically saying is that when the stimulus money ends in December of next year, the Governors are going to be down here with a bathtub asking us to fill it because if we don't do it, they are going to have to knock off thousands of people, millions in the country, because they don't have the money to provide for the program.

Now, providing extra dollars to States—and I predict it is going to happen. It will become an annual ritual for Congress, just as the doctors fix has become an annual ritual for doctors. Every year they come in. We are not going to cut the annual reimbursement. Next year it is 23 percent, I think. We are not going to fill the hole, and the Governors are going to be asking for the same kind of help. It is not only a mandate for them, it is going to become a mandate for us at a time when we are least able to handle anything like that.

So as a former Governor and a former mayor, a former county commissioner, I urge my colleagues to consider the impact this bill will have on their respective States. Think about it. Talk to your Governors. See what it is going to do to your States. I hope each of my colleagues will give careful thought to the potentially devastating effects it could have on each of their State budgets and to consult, as I said, with their Governors and to talk about the fact that if this happens, what is going to happen in terms of the Pac-Man eating up more money in their State and their inability to take care of primary and secondary education, higher education, and all of the other responsibilities State governments have.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Hawaii is recognized.

Mr. INOUYE. Mr. President, I rise today to address the Department of Defense appropriations bill for fiscal year 2010.

As my colleagues know, this afternoon the Senate received this measure from the House which represents a compromise between the bill passed by the House last July and what we passed this past October.

Since passage of the Senate measure, Vice Chairman COCHRAN and I and our staffs have spent countless hours in discussion with our colleagues in the House to thrash out the differences between our two bills. The product the Senate will consider represents the work of our discussions. While this is a House measure, I can assure my colleagues it is a very fair and balanced product.

The Defense appropriations portion of this measure totals $636.3 billion in discretionary spending, including more than $128 billion for the cost of our ongoing efforts in Iraq and Afghanistan.

In total, the Defense bill is $3.8 billion below the request of the President and within the subcommittee's allocation.

This bill represents the hard work over the past year of all the members of the Defense subcommittee. It contains funds that we believe will best meet the needs of the men and women who volunteer to serve our Nation in the military. The bill provides funding to increase their pay by 3.4 percent. It provides more than $30 billion to care for their health and the health of their families.

It provides support to families with loved ones serving in harm's way overseas and funding to ensure that their workplaces and quality of life back home are protected.

Of equal importance, the funding in this bill ensures that our forces in the field have the equipment and other tools required to meet their missions. Funding has been added to the President's request to provide for more MRAP vehicles to protect our forces from IEDs in Afghanistan.

Funds are provided for more medical evacuation and combat rescue helicopters to save our wounded troops. Funds have been added to sustain production of the C–17 Program so our forces in the field can be adequately resupplied, no matter where they are based.

This bill enhances research in lifesaving technologies and increases funds to care for our wounded personnel. It fully funds the priorities of Secretary Gates and our military commanders.

While I know some will criticize the fact that funds have been included at the request of Members of Congress, I remind my colleagues that, in total, this amount is less than 1 percent of the funding in the bill.

Moreover, all the so-called earmarks in the defense portion of this bill were in either the House or Senate bills. There are no ''airdropped'' earmarks in the defense funding included in this measure.

In addition to the defense portion of the bill, the House has added a little

more than 1 dozen provisions to provide a 2-month safety net to unemployed and nearly impoverished Americans and to extend critical provisions which are set to expire this month.

For individual Americans, provisions were included to extend, through February 28, 2010, expiring unemployment insurance benefits that were established in the American Recovery and Reinvestment Act.

Likewise, provisions were included to extend the 65-percent COBRA health insurance subsidy from 9 to 15 months for individuals who have lost their jobs and to extend the job lost eligibility date also through February 28, 2010.

Further, a provision was included to freeze the Department of Health and Human Services' poverty guidelines at 2009 levels in order to prevent a reduction in eligibility for programs such as Medicaid, food stamps, and school lunch programs through March 1 of next year.

This provision keeps struggling families from falling through the cracks.

In addition, provisions were included to provide $125 million to extend the Recovery Act program for small businesses. The program reduces lending fees charged to borrowers under the Small Business Administration's guaranteed loan programs and increases the Federal guarantee on certain small business loans.

The Recovery Act supported a resurgence in SBA small business lending, but funds were exhausted in November. The additional funding in this bill will help support lending for small businesses during the economic recovery by continuing fee relief for borrowers and encouraging lenders to extend credit to small businesses.

Further, this bill includes a short-term extension of the highway, transit, highway safety and truck safety programs. Without this extension, the highway program would be brought to a standstill and the Department of Transportation would be unable to reimburse States for eligible expenses.

In addition, several agencies—including the Federal Highway Administration, the National Highway Traffic Safety Administration, and the Federal Motor Carrier Safety Administration—would not have the funds necessary to pay their employees.

This is not your typical end-of-the-year Christmas tree; to the contrary, it is the bare minimum of programs which must be continued to provide for our less fortunate and our struggling small businesses.

It also allows for a 2-month extension of laws such as the PATRIOT Act, in order to allow more time for our authorizing committees to come to agreement on more permanent legislation.

The House has passed a compromise measure and forwarded it to the Senate because of the calendar. Today is December 16, and our Department of Defense has been operating on a continuing resolution for more than 2 months.

It is time we get on with the process and get this bill to the President. It is a good measure. Our troops deserve our support. Let's show we support those who volunteered to serve all of us by voting today to send this bill to the President.

As I close, I wish to thank the Defense Subcommittee staff for their dedication and hard work in putting this bill together. I wish to put into the RECORD the names of these staff members who have worked on this bill in a bipartisan fashion. They are:

Charlie Houy, Nicole Diresta, Kate Fitzpatrick, Katy Hagan, Kate Käufer, Ellen Maldonado, Rachel Meyer, Erik Raven, Gary Reese, Betsy Schmid, Renan Snowden, Bridget Zarate, Rob Berschinski, Stewart Holmes, Alycia Farrell, Brian Potts, Brian Wilson and Tom Osterhoudt.

Mr. President, it is my pleasure and privilege to be chairman of the committee. It is a great honor. I wish to make certain we express our gratitude to all these staff people. Without them, I would not be standing here at this moment.

I yield the floor.

The PRESIDING OFFICER. The Senator from Mississippi is recognized.

Mr. COCHRAN. Mr. President, I am glad I was here to hear the remarks of the distinguished Senator from Hawaii. I serve on that subcommittee of Defense Appropriations with him and get to observe, at close range, the skill and effort and courtesy that is reflected in his service as chairman of our committee. It is a pleasure to serve with him and it is an honor. He has provided leadership and cooperation in working with all Senators—not just members of our committee—to move forward in carrying out of duties by the Department of Defense through our appropriations process.

It is very important that the Senate approve, as soon as possible, the funding that is contained in the bill that our committee has reported to the Senate. It will help support and provide the resources necessary to carry out the missions of our men and women have in Afghanistan, Iraq, and around the world, safeguarding our freedom, protecting our security interests.

The Department of Defense is now operating under a continuing resolution that expires on Friday. This is an inefficient way of managing the support for our Department of Defense. It causes too much effort to be made by employees and men and women in the Defense Department, focusing on management, how to manage day-to-day operating expenses dealing with the challenges that too few dollars are provided in a way that gives people time to plan and then execute efficiently their missions and responsibilities.

This affects the support that is available to the men and women who are overseas and in harm's way.

The act contains funds necessary to provide medical care as well as family support for members of our Armed Forces and their families. During this time of war, it is very important that every effort be made to provide good medical care for those who are injured and wounded serving our country.

It is also important we support the families. There are funds in this legislation that do just that, trying to address the stresses that are associated with combat and deployment and separation.

I am disappointed the normal process has been circumvented, or at least delayed, and the other body has not appointed conferees to the Defense Appropriations conference committee. It is a disappointment also that the Defense Appropriations bill is used as a vehicle to move other initiatives that seem to be slowing down the process. These measures should be considered separately and addressed in a more thoughtful way, based on their own merits, not on the legislation they are tied to, to carry them through the legislative process.

I think attaching nondefense-related legislation to the Defense Appropriations Act for this fiscal year has been a mistake. It has been unnecessary, unfortunate, and it has resulted in delays and uncertainty.

I am sure there are Senators who can make suggestions for improving this bill. We are open to hear those concerns and do our best to respond to the suggestions from all Senators. We don't individually support all aspects of the agreement, but we think that, in total, it is a good bill. It ought to be passed, and it ought to be passed as soon as possible in recognition of our respect for our service members and their families.

Mr. INOUYE. Mr. President, there is nothing in rule XLIV which governs a message between the Houses in regard to disclosing earmarks. However, as chairman of the Appropriations Committee it is my belief that the committee should none the less attest that all earmarks have been fully disclosed. Accordingly I note that in the bill H.R. 3326 as passed by the House and explained in the statement offered by the chairman of the Subcommittee on Defense of the House of Representatives on December 16, 2009, each earmark in the bill has been disclosed in accord with rule XLIV.

Mr. CONRAD. Mr. President, section 401(c)(4) of S. Con. Res. 13, the 2010 budget resolution, permits the Chairman of the Senate Budget Committee to adjust the section 401(b) discretionary spending limits, allocations pursuant to section 302(a) of the Congressional Budget Act of 1974, and aggregates for legislation making appropriations for fiscal years 2009 and 2010 for overseas deployments and other activities by the amounts provided in such legislation for those purposes and so designated pursuant to section 401(c)(4). The adjustment is limited to the total amount of budget authority specified in section 104(21) of S. Con. Res. 13. For 2009, that limitation is $90.745 billion, and for 2010, it is $130 billion.

The Senate is considering H.R. 3326, the Department of Defense Appropriations Act, 2010. That legislation includes amounts designated pursuant to section 401(c)(4). Since this is the last of the 12 regular appropriations bills for 2010, I am revising previous adjustments made to the discretionary spending limits and the allocation to the Senate Committee on Appropriations for discretionary budget authority and outlays to reflect the final amount of designations made pursuant to section 401(c)(4). When combined with all previous adjustments, the total amount of adjustments for 2010 is $130 billion in discretionary budget authority and $101.178 billion in outlays. In addition, I am also further revising the aggregates for 2010 consistent with section 401(c)(4) to reconcile the amount of outlays estimated by the Congressional Budget Office for designated funding with the amount originally assumed in the 2010 budget resolution.

I ask unanimous consent that the following revisions to S. Con. Res. 13 be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

CONCURRENT RESOLUTION ON THE BUDGET FOR FISCAL YEAR 2010—S. CON. RES. 13; FURTHER REVISIONS TO THE CONFERENCE AGREEMENT PURSUANT TO SECTION 401(c)(4) ADJUSTMENTS TO SUPPORT ONGOING OVERSEAS DEPLOYMENTS AND OTHER ACTIVITIES

[In billions of dollars]

Section 101	
(1)(A) Federal Revenues:	
FY 2009	1,532.579
FY 2010	1,623.888
FY 2011	1,944.811
FY 2012	2,145.815
FY 2013	2,322.897
FY 2014	2,560.448
(1)(B) Change in Federal Revenues:	
FY 2009	0.008
FY 2010	−42.098
FY 2011	−143.820
FY 2012	−214.578
FY 2013	−192.440
FY 2014	−73.210
(2) New Budget Authority:	
FY 2009	3,675.736
FY 2010	2,910.707
FY 2011	2,842.766
FY 2012	2,829.808
FY 2013	2,983.128
FY 2014	3,193.887
(3) Budget Outlays:	
FY 2009	3,358.952
FY 2010	3,023.691
FY 2011	2,966.921
FY 2012	2,863.655
FY 2013	2,989.852
FY 2014	3,179.437

CONCURRENT RESOLUTION ON THE BUDGET FOR FISCAL YEAR 2010—S. CON. RES. 13; FURTHER REVISIONS TO THE CONFERENCE AGREEMENT PURSUANT TO SECTION 401(c)(4) TO THE ALLOCATION OF BUDGET AUTHORITY AND OUTLAYS TO THE SENATE APPROPRIATIONS COMMITTEE AND THE SECTION 401(b) SENATE DISCRETIONARY SPENDING LIMITS

[In millions of dollars]

	Initial Allocation/Limit	Adjustment	Revised Allocation/Limit
FY 2009 Discretionary Budget Authority	1,482,201	0	1,482,201
FY 2009 Discretionary Outlays	1,247,872	0	1,247,872
FY 2010 Discretionary Budget Authority	1,219,651	1	1,219,652
FY 2010 Discretionary Outlays	1,376,195	−157	1,376,038

CONCURRENT RESOLUTION ON THE BUDGET FOR FISCAL YEAR 2010—S. CON. RES. 13; FURTHER REVISIONS TO THE CONFERENCE AGREEMENT PURSUANT TO SECTION 401(c)(4) TO THE ALLOCATION OF BUDGET AUTHORITY AND OUTLAYS TO THE SENATE APPROPRIATIONS COMMITTEE AND THE SECTION 401(b) SENATE DISCRETIONARY SPENDING LIMITS—Continued

[In millions of dollars]

	Initial Allocation/Limit	Adjustment	Revised Allocation/Limit
FY 2009 Discretionary Outlays	1,247,872	0	1,247,872
FY 2010 Discretionary Budget Authority	1,219,651	1	1,219,652
FY 2010 Discretionary Outlays	1,376,195	−157	1,376,038

The PRESIDING OFFICER. The Republican leader is recognized.

SETTING PRECEDENT

Mr. MCCONNELL. Mr. President, I rise to make some observations about a matter that occurred in the Senate earlier this afternoon.

The plain language of the Senate precedent, the manual that governs Senate procedure, is that unanimous consent of all Members was required before the Senator from Vermont could withdraw his amendment while it was being read—unanimous consent.

Earlier today, the majority somehow convinced the Parliamentarian to break with the longstanding precedent and practice of the Senate in the reading of the amendment.

Senate procedure clearly states:

Under rule 15, paragraph 1, and Senate precedents, an amendment shall be read by the clerk before it is up for consideration or before the same shall be debated unless a request to waive the reading is granted.

It goes on to state that:

. . . the reading of which may not be dispensed with, except by unanimous consent, and if the request is denied, the amendment must be read and further interruptions are not in order.

Nothing could be more clear.

You may have heard that the majority cites an example in 1992 when the Chair made a mistake and allowed something similar to happen. But one mistake does not a precedent make.

For example, there is precedent for a Senator being beaten with a cane in the Senate. If mistakes were the rule, then the caning of Senators would be in order. Fortunately for all of us, it is not.

It is now perfectly clear that the majority is willing to do anything—anything—to jam through a 2,000-page bill before the American people or any of us have had a chance to read it, including changing the rules in the middle of the game.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Georgia is recognized.

Mr. CHAMBLISS. Mr. President, I rise today to speak about the decision to move the remaining detainees held at Guantanamo Bay Naval facility, or Gitmo, to the Thomson Correctional Center in Illinois.

The decision to transfer Gitmo detainees to the heartland of our country is irresponsible, a waste of taxpayer dollars, and contrary to the wishes of the American people.

Congress has included language permitting the transfer or detention of Gitmo detainees to the United States only under certain limited conditions in every relevant appropriations bill passed this year, including the recently passed Omnibus Appropriations Act. That is one of the reasons I voted against every single one of those bills.

The President now has made the decision to purchase the Thomson Correctional Center from the State of Illinois for the purpose of transferring and detaining Gitmo detainees.

Further, the President stated he will need to expend millions of additional dollars renovating and securing the facility when much has already been invested in the state-of-the-art facility at Guantanamo Bay. This unnecessary spending is an abuse of our tax dollars and one that holds dire national security consequences.

The administration claims that many of these detainees will continue to be held by the military in the same prison where the Department of Justice will hold average, ordinary criminals. What the administration fails to tell the American people is that these detainees will obtain the same rights as U.S. citizens the moment they step inside the United States. We have already seen detainees attempt to gain these same rights as Americans in our courts and have seen the courts grant them limited rights without them being inside the United States.

In habeas corpus cases where the court has ruled, 30 out of 38 Gitmo detainees have been found to be unlawfully detained and their release has been ordered. After reviewing the classified biographies on some of these individuals, it is clear from these decisions that the courts are not in a position to judge matters of war and cannot when they are bound by our criminal justice system. It is not designed to handle war criminals.

The courts do not adequately consider the threat these individuals pose to U.S. interests or will pose in the future when they return to terrorism. President Obama cites the authorization for the use of military force as legal justification for continuing the detention of these terrorists. However, the courts have already indicated that these detainees cannot be indefinitely held. I wonder if the administration considered this when it decided to move Gitmo detainees to the United States.

This administration may face the same problem as the last administration did in justifying to a U.S. court the continuing detention of these terrorists. Only this time, the court will have a remedy.

It is foreseeable that some, and possibly many, of those detainees will be ordered released by our courts. The administration has tried to assure the public that our immigration laws will prohibit the release of those individuals into the United States. But, once again, this administration fails to appreciate the limits of our legal system.

Once these detainees are physically present in the United States, prior judicial precedent indicates that the government can only detain an individual while immigration removal proceedings are ongoing for a maximum of 6 months. If a detainee cannot be transferred or deported, they will be released, freed into the United States, after 6 months. This is much more than just moving Guantanamo north.

On the other hand, if the administration is able to secure the transfer of these detainees to another country, we can be sure to watch the recidivism rates rise. The Department of Defense's last unclassified fact sheet on recidivism reported that 14 percent of the former Gitmo detainees returned to terrorism after their release or their transfer. This is almost one out of every seven detainees transferred. This number is much larger now after 8 months and countless transfers of the most serious terrorists.

Some of the detainees transferred openly admit their affiliation with a terrorist organization or that they were combating U.S. forces in Afghanistan. Confirming this, two former Gitmo detainees transferred to Saudi Arabia announced earlier this year that they were now the leaders of al-Qaida in the Arabian peninsula. Another detainee, Ali bin Ali Aleh, lived with Abu Zubaydah in Pakistan and was identified on a list of names in Khalid Shaikh Mohammed's possession when KSM was captured. Ali bin Ali Aleh was determined not to be an enemy combatant and ordered to be released by a U.S. court in May of this year. He was transferred to Yemen in September.

Maybe some of my colleagues have seen the recent headlines indicating that some European countries are willing to accept these detainees. In fact, detainees have recently been transferred to Belgium, Ireland, Hungary, and Italy. However, the American people are not fooled by these headlines. Of the 779 detainees held since 2001 at Guantanamo Bay, our European partners have accepted only 37. The vast majority of detainees—almost 400—have been transferred to four countries: Afghanistan, Saudi Arabia, Pakistan, and Yemen. These four countries are either currently in conflict or actively combating al-Qaida. In all four of these countries, the threat from al-Qaida and associate militants has done nothing but increase over the past few years. Yet the United States is sending back hundreds of terrorists to the most volatile regions of the world—South Asia, which poses the greatest terrorist threat currently to the homeland and to the Arabian peninsula, which I believe will present itself as the next greatest threat to the United States.

The decision to move these terrorists to the United States may force the administration to choose between freeing terrorists into Illinois or transferring them back to the center of the battle. Is this the policy position we want to put our country in while we are still combating terrorism?

No one doubts the security of our prisons to safely hold these individuals. I doubt the ability of our laws and judicial system to ensure that these terrorists are convicted or kept in prison. Prohibiting the detainees from entering the United States is the only guarantee. However, the decision to move the remaining terrorists at Gitmo to the heart of this country shattered any remaining hope for this guarantee. This is yet another step in a series of poor policy decisions which is leading our country in the wrong direction.

I am disappointed by this decision, obviously. But I can only imagine how the residents of Illinois feel about it. I know Georgians would not be pleased with housing over 200 of the most serious and hardened terrorists in the world in their backyard.

I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER (Mrs. SHAHEEN). The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. DURBIN. Madam President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. DURBIN. Madam President, I wish to respond to my friend from Georgia, who just stepped off the floor, about the transfer of detainees from Guantanamo because he misstated a few things that I do not want to stay on the record.

First, he suggested that these detainees would be freed in Illinois. Not so. The plan of this administration is not to free them; the plan is to imprison them in the most secure prison in the United States of America. It is in Thomson, IL, 150 miles from Chicago. I was there a few weeks ago. It is a supermax prison built 7 years ago and never fully occupied. Now they are going to build an additional fence around it. It will be more secure than any prison in America. They will be freed into the most secure prison in America and they are not coming out until such time as there is a resolution of whatever their issues may be or they pass away.

I might also say that the current law in the United States prohibits the President of the United States from releasing these detainees in the United States. Those statements by the Senator from Georgia are just flat incorrect.

He is entitled to his position—and others share it—that we should not close Guantanamo. I believe we should. On my side of this argument would be the following people who have called for the closure of Guantanamo: President George W. Bush; Secretary of State and former Chairman of the Joint Chiefs of Staff Colin Powell; Secretary of Defense under President Bush and under President Obama, Robert Gates; former Secretary of State and domestic policy adviser Condoleezza Rice; GEN David Petraeus, and 33 other generals, in addition to President Barack Obama.

This argument that closing Guantanamo endangers the United States ignores the obvious. The people entrusted with the responsibility of protecting the United States have called for the closure of Guantanamo. Yesterday, Robert Gibbs, press secretary to President Obama, was asked about this decision to transfer. He said that on more than 30 occasions—I am not sure of the timeframe, whether it was this year or a longer period of time—but on more than 30 occasions, they have found direct linkage of terrorist recruitment activity and the use of Guantanamo as an illustration of why people needed to convert to terrorism around the world. It is still being actively used for recruitment.

If the Senator from Georgia would go back a few weeks and read Newsweek magazine, one of their reporters was captured in Tehran and held in captivity for almost 4 months. He told a story of how he was first incarcerated in a prison in Tehran. As he arrived, his jailer said to him: Welcome to Abu Ghraib and Guantanamo, American.

So for us to believe that the rest of the world does not have a negative image of Guantanamo and it is not being used against our troops is to ignore the obvious.

There are some in this body who are hidebound to keep Guantanamo open at any costs. I will tell you, the cost is too high. If the continuation of Guantanamo means danger to our troops, we owe it to them to close it. Presidents have reached that conclusion, people in charge of national security have reached that conclusion, and we should as well.

Then there is this notion about the danger of incarcerating terrorists in the United States. For the record, over 350 convicted terrorists are currently imprisoned in the United States, all over the United States. In my home State of Illinois, 35 convicted terrorists are in prison today. The most recent incarceration involves a man arrested shortly after 9/11 in Peoria, IL, an unlikely hotbed of terrorism and spy activity, but, in fact, this man going to school in Peoria, IL, through his communications was linked with al-Qaida. He served time in a Navy brig in South Carolina, if I am not mistaken, and eventually was tried in the courts of Peoria, IL, convicted and now incarcerated in Marion, IL, in southern Illinois.

I heard not one word of criticism when this took place under the previous administration. The belief was this man had to answer for the crimes he was charged with and serve time in our prison system as a result of it. Never—not once, not one time—did I ever hear any Congressman of either political party say: Boy, it is unsafe to try him in Peoria or it is unsafe to incarcerate him in southern Illinois. It has never been said.

What happens to these people when they go into our supermax prisons, where no one has ever escaped? They disappear, as they should. They are where they ought to be—isolated and away from causing harm to anyone.

When President Obama was looking for an alternative to Guantanamo, we came forward. One of the mayors of a small town in Illinois—Thomson, IL—with just several hundred people living there, wrote to the Governor of our State and to me and said: I have a big old prison the State built and never opened—built it in 2001. It has the capacity of several thousand prisoners, and the State could never afford to open it. We had hoped that this prison would create a lot of local jobs for us. Can you find a use for it at the Federal level?

The Obama administration took a hard look at this for a long period of time. Part of it was done confidentially, and then they came out publicly and said: We are seriously interested.

The Senator from Georgia said earlier: Well, the people of Illinois are against this.

Well, I would say to my friend from Georgia, come on down to Thomson, IL. Come down and see the people who are overwhelmingly supportive—and not just Democrats, believe me. Local State representative Jim Sacia is a Republican and a former FBI agent. He said we would be idiots not to take this offer from the Federal Government. He is right. Three thousand jobs. I don't know that there is a Senator here if you said to him: Would you be interested in 3,000 jobs in the midst of a recession, who wouldn't stand up and say: Let's talk.

Well, we did. So it is 3,000 new jobs at this prison when it is opened as part of the Bureau of Prisons and part of the Department of Defense.

How many Guantanamo detainees will be sent there? Fewer than 100. We have 35 in our prisons already. Life has not changed in my home State of Illinois, nor has it changed in any other State where they are incarcerated. It would not change in Thomson, IL. These people can be held safely and securely. I trust our men and women in the military to do that, and the Members of the Senate should do so as well.

These 3,000 jobs are going to be a Godsend to an area with 11 percent unemployment. First, there will be a lot of construction jobs, and we can use those. Those are good-paying jobs for Americans right here at home. Then those who work for the Bureau of Prisons are going to be paid a good salary and receive good benefits, the kind of salary you can use to build a family, a community, a neighborhood. These will be people who will be buying homes—3,000 of them. They will be buying homes, cars, shopping for appliances, and going to the local shopping malls. Is that going to be good for the economy? You bet it is. It is just what we need, and it is just what this area of the State wants. This argument that we somehow will oppose it is just wrong.

There is a local Congressman, who is a friend of mine—a Republican Congressman—who opposes it. We have talked about it. We just don't see eye to eye on it. But even in Rockford, IL, the largest city in his district, which is northeast of Thomson, the city council in Rockford passed a resolution of approval of this Thomson prison, 12 to 2. In county after county, State and local governments—I should say local county governments, are coming out in favor of this Thomson prison. Those who come to the Senate floor and argue otherwise don't know the facts. When they know the facts, they will realize we are prepared to do this.

Now the question is whether the Senate will stand behind the President, stand behind our security advisers who believe this is in the best interest of the United States. I think it is. It isn't the first time Illinois has been called on to do something extraordinary for our country. The first supermax prison in our Federal system was built in Marion, IL, years and years ago. There was controversy. This was the most secure prison in America. But I will tell you, the people of southern Illinois rallied behind it. It has been a prison with a lot of great professionals who have worked there. They have done their jobs and done them well.

When I go down to Marion, IL, and talk to them about Guantanamo detainees, they say: Senator, listen. Send them here. We will take care of them. We can point out among those who are incarcerated at Marion prison those who were engaged in al-Qaida terrorism, Colombian drug gangs, Mexican drug cartels, some of the meanest, toughest most violent gang bangers from the cities in the Midwest—and they are held safely every day.

I will tell you, when I hear people say they do not trust our prison system to hold a handful or 50 or whatever the number may be—less than 100—of these Guantanamo detainees, they ought to meet the men and women who do it every single day in America, and do it well. They should realize these detainees will be held by our military, the Department of Defense employees. Those are the ones we can trust to do it.

So I would urge my friends and others who have spoken earlier—Senator MCCONNELL came to the Senate floor earlier. It has become, unfortunately, a party position now that it is a bad idea. Earlier, Senator MCCAIN and Senator GRAHAM on the Republican side of the aisle didn't argue against the transfer of these detainees. They understand these prisoners aren't larger than life. They have been in prison for 8 years. Frankly, I don't know how much longer they will stay there. But as long as they are a threat to the United States, they will.

Madam President, I would like to at this point address an issue which came up earlier on the Senate floor.

Something unusual happened on the floor of the Senate today, Madam President. It happens but rarely. Under the rules of the Senate, amendments and bills can be read, if a Member requests, and we usually ask unanimous consent to dispense with the reading. And, routinely, that is done. It is done every day on scores of different things.

Today, Senator SANDERS of Vermont offered an amendment near and dear to his heart on single-payer health care reform, and it turned out to be a voluminous amendment—800 pages long. When the time came to ask consent that it not be read, there was an objection from Senator COBURN of Oklahoma. He insisted that it be read. Our poor clerking staff up here—the clerks of the Senate—started reading this bill, and they read on for almost 2 hours or more.

As they were reading it, it came to our attention that Senator SANDERS of Vermont had authority under the Senate rules to withdraw his amendment and to stop the reading of the amendment.

I wasn't aware of that because I can't recall that has ever happened since I have been here. But I made a point—since many years ago I was a parliamentarian of the Illinois State Senate and tried to at least read the rules from time to time—to turn to rule XV, section 2, in the Standing Rules of the Senate, and here is what it says:

> Any motion, amendment, or resolution may be withdrawn or modified by the mover at any time before a decision, amendment or ordering of the yeas and nays, except a motion to reconsider, which shall not be withdrawn without leave.

In other words, until action was taken on the Sanders amendment, he had the authority under rule XV, paragraph 2 to withdraw his amendment, which he did.

Some have come to the floor and protested and said this was extraordinary, and it can't be backed up by the Senate rules. But I refer them to this rule, which is explicit, and that no action had taken place on this amendment other than the introduction of the amendment and reading. So, as it says here, ''any time before a decision, amendment, or ordering of the yeas and nays.'' I think that is a clear case.

I have since read an earlier ruling by the Chair relative to the same rule that goes back several decades, so the ruling of the Chair today, or at least the finding of the Chair, was consistent with the rules of the Senate. But the strategy that came out in the ordering of this amendment to be read is pretty clear when it comes to health care. The Republican strategy is clear to anyone who is watching the debate: They do not want amendments. In fact, they just don't want us to vote on health care reform. There comes a time when people make the best arguments they can and the Senate makes a decision, and that is what we are facing. That is what we want. We would like to do that in a timely fashion.

Members here believe we can do that in a responsible way and move this health care reform bill to a point of a vote—a cloture vote, with a 60-vote requirement—and do that in a way that we can find the sentiment in the Senate on this important measure and just maybe go home for Christmas, which a lot of us would like to do. We have been away from our families for quite a while.

During the course of this debate, we have been spending a lot of time on the bill itself. I usually like to give people an idea by holding up this 2,074-page bill. It took a lot of work to get to this point. The managers' amendment to this will be several hundred pages, I imagine.

People say: Why is it so big? It is big because we are changing the health care system in America, which is one-sixth of our economy. You can imagine all the different moving parts in this complicated health care system that we address with this bill.

During this period of time, the Republicans have not offered any alternative or substitute. I thought that would be their first motion, to come forward and say: That is the Democratic plan to change the health care system in America, but you should see the Republican plan, how much better it is. They didn't do that because there is no Republican alternative. There is no Republican substitute.

Last week, when I went to the Senate Republican Web site—and I invite people to do the same—I found there was only one bill printed there on health care reform. It was the Democratic bill, not any bill that has been offered by the Republican side. The reason is this is hard work. Putting a bill like this together, getting experts to look at it and decide whether it is going to save money or cost money, it takes time. We have taken that time to do it, and do it right, and they have not. So they are either not up to the challenge of preparing an alternative bill, or they are content with the current system.

I guess some people are content with the current system. Among those who are content with it are the CEOs of health insurance companies. They like this system. They make a lot of money. They do it at the expense of a lot of people who need health care and end up being turned down. So, unfortunately, the Republicans have no constructive proposals to improve our bill. Each and every amendment, almost without exception, has been to send the bill back to committee; to stop working on it, and let's do this another day. All they want to do on the bill is to delay it, as they tried to do today with the reading of the Sanders amendment.

Senator JUDD GREGG of New Hampshire is a friend of mine. He and his wife Kathy and my wife Loretta and I have traveled together on official business of the Senate. I like him. He is a smart guy. He is going to retire, and he, in his wisdom, decided to leave a playbook for the Republican side of the aisle, which they shared. It is page after page of ways to slow down and stop the Senate from acting. Senator GREGG is entirely within his rights as a Senator to do it. What I read in his memo was accurate, but the intent and motive are clear: He wanted to stop this bill from moving in order, and that became the real cause on the Republican side of the aisle. They took a page out of Senator GREGG's playbook today with Senator COBURN's demanding the amendment be read. But it didn't work.

Madam President, I ask unanimous consent to have printed in the RECORD a colloquy between former Senators Adams and Packwood on the floor of the Senate on September 24, 1992.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

TAX ENTERPRISE ZONES ACT

(Senate—September 24, 1992), [Page: S14919]

The Senate continued with the consideration of the bill.

The PRESIDING OFFICER. The Senator from Washington is recognized.

AMENDMENT NO. 3173

(Purpose: To amend the Internal Revenue Code of 1986 to deny the benefits of certain export subsidies in the case of exports of certain unprocessed timber, and to establish rural development programs for certain rural communities and small businesses that have been adversely affected by a declining timber supply and changes in the timber industry in the Pacific Northwest)

Mr. ADAMS. Mr. President, I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Washington [Mr. Adams] proposes an amendment numbered 3173.

Mr. ADAMS. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

Mr. PACKWOOD. Mr. President, I object.

The PRESIDING OFFICER. Objection is heard. The clerk will read the amendment.

The assistant legislative clerk continued reading the amendment.

Mr. ADAMS. Mr. President, I ask unanimous consent that further reading of the amendment be dispensed with.

Mr. PACKWOOD. I object.

The PRESIDING OFFICER. Objection is heard.

Mr, ADAMS. Mr. President, parliamentary inquiry? I have a parliamentary inquiry of the Chair. Is it in order, during the reading of the amendment, without it being dispensed with, for the floor leader and the opponent of the amendment to have a discussion?

The PRESIDING OFFICER. The regular order, as the Chair is advised by the Parliamentarian, is that the amendment is to be read because objection has been heard to the unanimous-consent request.

The clerk will read the amendment.

The assistant legislative clerk continued reading the amendment.

Mr. ADAMS. Mr. President, I ask permission to withdraw the amendment.

The PRESIDING OFFICER. The Senator has a right to withdraw the amendment.

Mr. ADAMS. I withdraw the amendment.

The PRESIDING OFFICER. The amendment is withdrawn.

The amendment (No. 3173) was withdrawn.

The text of the amendment (No. 3173) is as follows:

At the end of title VIII, insert the following new sections:

Mr. DURBIN. Incidentally, Madam President, that is the colloquy I referred to earlier where the Chair made exactly the same ruling on that day as was made today, the finding in terms of rule XV, paragraph 2.

I also ask unanimous consent to have printed in the RECORD the memorandum prepared by Senator GREGG for the Republican side of the aisle concerning the rights of the minority in the Senate, which I have mentioned earlier, and largely includes the rights to slow down and stop the activity of the Senate.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

FOUNDATION FOR THE MINORITY PARTY'S RIGHTS IN THE SENATE (FALL 2009)

The Senate rules are designed to give a minority of Senators the right to insist on a full, complete, and fully informed debate on all measures and issues coming before the Senate. This cornerstone of protection can only be abrogated if 60 or more Senators vote to take these rights away from the minority.

I. Rights Available to Minority Before Measures are Considered on Floor (These rights are normally waived by Unanimous Consent (UC) when time is short, but any Senator can object to the waiver.)

New Legislative Day, An adjournment of the Senate, as opposed to a recess, is required to trigger a new legislative day. A new legislative day starts with the morning hour, a 2-hour period with a number of required procedures. During part of the ''morning hour'' any Senator may make non-debatable motions to proceed to items on the Senate calendar.

One Day and Two Day Rules—The 1-day rule requires that measures must lie over one ''legislative day'' before they can be considered. All bills have to lie over one day, whether they were introduced by an individual Senator (Rule XIV) or reported by a committee (Rule XVII). The 2-day rule requires that IF a committee chooses to file a written report, that committee report MUST contain a CBO cost estimate, a regulatory impact statement, and detail what changes the measure makes to current law (or provide a statement why any of these cannot be done), and that report must be available at least 2 calendar days before a bill can be considered on the Senate floor. Senators may block a measure's consideration by raising a point of order if it does not meet one of these requirements.

''Hard'' Quorum Calls—Senate operates on a presumptive quorum of 51 senators and quorum calls are routinely dispensed with by unanimous consent. If UC is not granted to dispose of a routine quorum call, then the roll must continue to be called. If a quorum is not present, the only motions the leadership may make are to adjourn, to recess under a previous order, or time-consuming motions to establish a quorum that include requesting, requiring, and then arresting Senators to compel their presence in the Senate chamber.

II. Rights Available to Minority During Consideration of Measures in Senate (Many of these rights are regularly waived by Unanimous Consent.)

Motions to Proceed to Measures—with the exception of Conference Reports and Budget Resolutions, most such motions are fully debatable and 60 votes for cloture is needed to cut off extended debate.

Reading of Amendments and Conference Reports in Entirety—In most circumstances, the reading of the full text of amendments may only be dispensed with by unanimous consent. Any Senator may object to dispensing with the reading. If, as is often the case when the Senate begins consideration of a House-passed vehicle, the Majority Leader offers a full-text substitute amendment, the reading of that full-text substitute amendment can only be waived by unanimous consent. A member may only request the reading of a conference report if it is not available in printed form (100 copies available in the Senate chamber).

Senate Points of Order—A Senator may make a point of order at any point he or she believes that a Senate procedure is being violated, with or without cause. After the presiding officer rules, any Senator who disagrees with such ruling may appeal the ruling of the chair—that appeal is fully debatable. Some points of order, such as those raised on Constitutional grounds, are not ruled on by the presiding officer and the question is put to the Senate, then the point of order itself is fully debatable. The Senate may dispose of a point of order or an appeal by tabling it; however, delay is created by the two roll call votes in connection with each tabling motion (motion to table and motion to reconsider that vote).

Budget Points of Order—Many legislative proposals (bills, amendments, and conference reports) are subject to a point of order under the Budget Act or budget resolution, most of which can only be waived by 60 votes. If budget points of order lie against a measure, any Senator may raise them, and a measure cannot be passed or disposed of unless the points of order that are raised are waived. (See *http://budget.senate.gov/republican/pressarchive/PointsofOrder.pdf*)

Amendment Process

Amendment Tree Process and/or Filibuster by Amendment—until cloture is invoked, Senators may offer an unlimited number of amendments—germane or non-germane—on any subject. This is the fullest expression of a ''full, complete, and informed'' debate on a measure. It has been necessary under past Democrat majorities to use the rules governing the amendment process aggressively to ensure that minority Senators get votes on their amendment as originally written (unchanged by the Majority Democrats.)

Substitute Amendments—UC is routinely requested to treat substitute amendments as original text for purposes of further amendment, which makes it easier for the majority to offer 2nd degree amendments to gut 1st degree amendments by the minority. The minority could protect their amendments by objecting to such UC's.

Divisible Amendments—amendments are divisible upon demand by any Senator if they contain two or more parts that can stand independently of one another. This can be used to fight efforts to block the minority from offering all of their amendments, because a single amendment could be drafted, offered at a point when such an amendment is in order, and then divided into multiple component parts for separate consideration and votes. Demanding division of amendments can also be used to extend consideration of a measure. Amendments to strike and insert text cannot be divided.

Motions to Recommit Bills to Committee With or Without Instructions—A Senator may make a motion to recommit a bill to the committee with or without instructions to the Committee to report it back to the Senate with certain changes or additions. Such instructions are amendable.

After Passage: Going to Conference,Motions to Instruct Conferees, Matters Out of Scope of Conference

Going to Conference—The Senate must pass 3 separate motions to go to conference: (1) a motion to insist on its amendments or disagree with the House amendments; (2) a motion to request/agree to a conference; and (3) a motion to authorize the Chair to appoint conferees. The Senate routinely does this by UC, but if a Senator objects the Senate must debate each step and all 3 motions may be filibustered (requiring a cloture vote to end debate).

Motion to Instruct Conferees—Once the Senate adopts the first two motions, Senators may offer an unlimited number of motions to instruct the Senate's conferees. The motions to instruct are amendable—and divisible upon demand—by Senators if they contain more than one separate and distinct instruction.

Conference Reports, Out of Scope Motions—In addition to demanding a copy of the conference report to be on every Senator's desk and raising Budget points of order against it, Senators may also raise a point of order that it contains matter not related to the matters originally submitted to the conference by either chamber. If the Chair sustains the point or order, the provision(s) is stricken from the conference agreement, and the House would then have to approve the measure absent the stricken provision (even if the House had already acted on the conference report). The scope point of order can be waived by 60 Senators.

Availability of Conference Report Language. The conference report must be publicly available on a website 48 hours in advance prior to the vote on passage.

Mr. DURBIN. Madam President, I would just say that when Senator MCCONNELL came to the floor after the ruling and the decision of the Chair, he said the plain language of the Senate precedent—the manual that governs Senate procedure—is that unanimous consent of all Members was required before the Senator from Vermont could withdraw his amendment while it was being read. He said it required unanimous consent. But that is not what the language of the Senate rules say that I have read. They say a Senator has, as a matter of right under rule XV, paragraph 2, to withdraw his amendment before action is taken. In this case, as I mentioned earlier, the argument back in 1992 backs up the Parliamentarian's decision in that interpretation of the rule.

So I would say it didn't work today to stop or slow down the Senate. Currently, we are not technically debating health care reform. What is before us now is the Department of Defense appropriations bill from the House, which I hope we can move on quickly. I think it is not controversial. It is a matter of finding money for our troops who are risking their lives overseas and supporting their families at home and providing health care for members of the military and their families. I don't think there is much debate about that.

It also extends the unemployment benefits that people need across America, which passed with a 97-to-0 vote, if I am not mistaken, not that long ago—the last time it was considered. So these are matters which should move along, and we should be able to do it in a fairly straightforward way. I would hope we can show some bipartisanship when it comes to our men and women in uniform and approve the Department of Defense appropriations bill, which does not contain anything controversial beyond what I have just described. We can then get back to the health care reform bill. I think it is important that at some point we bring this to a vote, to find if we indeed have the 60 votes for health care reform. I sincerely hope we do.

I will close by saying this health care reform bill has its critics, but it also has several features which can't be denied.

The first of those features that have been verified by the Congressional Budget Office: This bill does not add to the deficit of the United States; it reduces the deficit by $130 billion over 10 years and $650 billion, moreover, the following 10 years.

We have also received reports from the Congressional Budget Office that the result of this bill will be a decline in the increase in the cost of health insurance premiums—something we desperately need.

It is a bill that will also extend health insurance coverage to 30 million more Americans who do not have it today—50 million uninsured Americans; 30 million of them, 60 percent of them, will have the protection of health insurance coverage. Ninety percent of Americans will have health insurance coverage—the highest percentage in the history of the United States of America—as a result of this bill.

This bill addresses directly the issue of whether health insurance companies can continue to deny coverage when people need it the most. We know stories from our own life experience and our families' and people who write to our offices, that people in the most need of health insurance protection are often turned down by the companies. They pore through the applications and say: You failed to disclose a preexisting condition. They say: Your amount of coverage has lapsed; your child is too old to be covered by your family plan—the list goes on and on.

Finally, some of the most egregious abuses by health insurance companies are addressed in this bill, and consumers across America are given the legal power to fight back and the legal power to be protected. That is why this bill is important and why it is worth passing, all the criticism notwithstanding.

I might also say that it is a bill that is critically important for the future of Medicare. If we do nothing, Medicare is going broke in 7 or 8 years, but we are told this bill will extend the life of Medicare up to 10 more years. That is good news, to put Medicare on sound financial footing, so our seniors like that.

The majority leader of the Senate came to the floor 2 days ago to announce something else that will be part of the conference committee here. The so-called doughnut hole, that gap in coverage for prescription drugs under

Medicare, is going to be filled so that seniors will no longer have that period of uncertainty where their bills have reached a level where they are disqualified from payment—the so-called doughnut hole. It will be filled. It will give them peace of mind that if they have expensive pharmaceuticals, they will have no interruption in coverage in the future when it comes to those pharmaceuticals.

For seniors, these are two major things—to put Medicare on sound financial footing and to fill the doughnut hole under the Medicare prescription part of the program.

It also is going to give seniors for the first time access to the kind of preventive care—regular checkups—they need for peace of mind and so doctors and professionals can catch problems before they get worse.

This bill is a positive bill, a positive step forward.

Yesterday, we had a chance as a Senate Democratic caucus to meet with President Obama. We went to the White House, the Executive Office Building, and the President talked to us about what this bill means. He reminded us that seven Presidents have tried to do this and failed. He told us when he started this trek that he wanted to be the last President to deal with health care reform because he wanted to get it done. I feel the same way. I think the American people feel the same way.

I am sure there is confusion. There have been a lot of misstatements made about death panels and things that really have no basis in fact. But people should be confident that when the AARP, the American Association of Retired Persons, stands up and says this is a good bill for the seniors in America under Medicare and Social Security and for their families; when medical professionals, doctors and medical professionals, stand up and say this is a good bill, that we have the kind of support we need to say to the American people that this is an important step forward in health care protection in America.

It is time for us to make history and pass this bill. Let's do it and do it in time for Members to enjoy Christmas with their families.

I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. DURBIN. Madam President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

MORNING BUSINESS

Mr. DURBIN. I ask unanimous consent that the Senate proceed to a period of morning business, with Senators permit to speak for up to 10 minutes each.

The PRESIDING OFFICER. Without objection, it is so ordered.

HONORING OUR ARMED FORCES

Mrs. BOXER. Madam President, I rise today to pay tribute to three young Americans who have been killed in Iraq since July 28. This brings to 882 the number of servicemembers either from California or based in California that have been killed while serving our country in Iraq. This represents 20 percent of all U.S. deaths in Iraq.

SPC Lukas C. Hopper, 20, of Merced, CA, died October 30, southeast of Karadah, Iraq, of injuries sustained during a vehicle roll-over. Private First Class Hopper was assigned to the 1st Battalion, 505th Parachute Infantry Regiment, 3rd Brigade Combat Team, 82nd Airborne Division, Fort Bragg, NC.

SPC Christopher M. Cooper, 28, of Oceanside, CA, died October 30 in Babil province, Iraq, of injuries sustained from a noncombat related incident. Specialist Cooper was assigned to the 2nd Battalion, 28th Infantry, 172nd Infantry Brigade, Schweinfurt, Germany.

PVT Jhanner A. Tello, 29, of Los Angeles, CA, died December 10 in Baghdad, Iraq, of injuries sustained from a noncombat related incident. Private Tello was assigned to the 3rd Aviation Support Battalion, 227th Aviation Regiment, 1st Air Cavalry Brigade, 1st Cavalry Division, Fort Hood, TX.

I would also like to pay tribute to the 27 soldiers from California or based in California who have died while serving our country in Operation Enduring Freedom since July 28.

SPC Matthew K.S. Swanson, 20, of Lake Forest, CA, died August 8 at the National Naval Medical Center in Bethesda, MD, of injuries sustained during a vehicle roll-over July 19 in Logar province, Afghanistan. Specialist Swanson was assigned to the 3rd Brigade Special Troops Battalion, 3rd Brigade Combat Team, 10th Mountain Division, Light Infantry, Fort Drum, NY.

LCpl Javier Olvera, 20, of Palmdale, CA, died August 8 while supporting combat operations in Helmand province, Afghanistan. Lance Corporal Olvera was assigned to 2nd Battalion, 8th Marine Regiment, 2nd Marine Division, II Marine Expeditionary Force, Camp Lejeune, NC.

PFC Brian M. Wolverton, 21, of Oak Park, CA, died August 20 in Kunar province, Afghanistan, of wounds suffered when insurgents attacked his unit with indirect fire. Private First Class Wolverton was assigned to the 1st Battalion, 32nd Infantry Regiment, 3rd Brigade Combat Team, 10th Mountain Division, Light Infantry, Fort Drum, NY.

LCpl Donald J. Hogan, 20, of San Clemente, CA, died August 26 while supporting combat operations in Helmand province, Afghanistan. Lance Corporal Hogan was assigned to 1st Battalion, 5th Marine Regiment, 1st Marine Division, I Marine Expeditionary Force, Camp Pendleton, CA.

CPT John L. Hallett III, 30, of Concord, CA, died August 25 in southern Afghanistan, of wounds suffered when enemy forces attacked his vehicle with an improvised explosive device. Captain Hallett was assigned to the 1st Battalion, 17th Infantry Regiment, 5th Stryker Brigade, 2nd Infantry Division, Fort Lewis, WA.

SPC Tyler R. Walshe, 21, of Shasta, CA, died August 31 in southern Afghanistan, of wounds suffered when enemy forces attacked his unit with an improvised explosive device. Specialist Walshe was assigned to the 1st Battalion, 17th Infantry Regiment, 5th Stryker Brigade, 2nd Infantry Division, Fort Lewis, WA.

SPC Jonathan D. Welch, 19, of Yorba Linda, CA, died August 31 in Shuyene Sufia, Afghanistan, of wounds suffered when enemy forces attacked his unit with an improvised explosive device. Specialist Welch was assigned to the 1st Battalion, 17th Infantry Regiment, 5th Stryker Brigade, 2nd Infantry Division, Fort Lewis, WA.

PO3 James R. Layton, 22, of Riverbank, CA, died September 8 in Kunar province, Afghanistan, while supporting combat operations. Petty Officer 3rd Class Layton was assigned to an embedded training team with Combined Security Transition Command in Afghanistan.

Capt Joshua S. Meadows, 30, of Bastrop, TX, died September 5 while supporting combat operations in Farah province, Afghanistan. Captain Meadows was assigned to 1st Marine Special Operations Battalion, Marine Corps Forces Special Operations Command, Camp Pendleton, CA.

TSgt James R. Hornbarger, 33, of Castle Rock, WA, died September 12 as a result of a non-hostile incident in the Mediterranean. Technical Sergeant Hornbarger was assigned to the 9th Aircraft Maintenance Squadron, Beale Air Force Base, CA.

SGT Joshua M. Hardt, 24, of Applegate, CA, died October 3 in Kamdesh, Afghanistan, of wounds suffered when enemy forces attacked his contingency outpost with small arms, rocket-propelled grenade and indirect fires. Sergeant Hardt was assigned to the 3rd Squadron, 61st Cavalry Regiment, 4th Brigade Combat Team, 4th Infantry Division, Fort Carson, CO.

SSgt Aaron J. Taylor, 27, of Bovey, MN, died October 9 while supporting combat operations in Helmand province, Afghanistan. Staff Sergeant Taylor was assigned to Marine Wing Support Squadron 372, Marine Wing Support Group 37, 3rd Marine Aircraft Wing, I Marine Expeditionary Force, Camp Pendleton, CA.

LCpl Alfonso Ochoa, Jr., 20, of Armona, CA, died October 10 while supporting combat operations in Farah province, Afghanistan. Lance Corporal Ochoa was assigned to 2nd Battalion, 3rd Marine Regiment, 3rd Marine Division, III Marine Expeditionary Force,

Marine Corps Base Hawaii, Kaneohe Bay.

SPC Jesus O. Flores, Jr., 28, of La Mirada, CA, died October 15 in Kandahar province, Afghanistan, of wounds suffered when enemy forces attacked his vehicle with an improvised explosive device. Specialist Flores was assigned to the 569th Mobility Augmentation Company, 4th Engineer Battalion, Fort Carson, CO.

SPC Michael A. Dahl, Jr., 23, of Moreno Valley, CA, died October 17 in Argahndab, Afghanistan, of wounds suffered when enemy forces attacked his vehicle with an improvised explosive device. Specialist Dahl was assigned to 1st Battalion, 17th Infantry Regiment, 5th Stryker Brigade, 2nd Infantry Division, Fort Lewis, WA.

LCpl David R. Baker, 22, of Painesville, OH, died October 20 while supporting combat operations in Helmand province, Afghanistan. Lance Corporal Baker was assigned to 1st Battalion, 5th Marine Regiment, 1st Marine Division, I Marine Expeditionary Force, Camp Pendleton, CA.

SPC Kyle A. Coumas, 22, of Lockeford, CA, died October 21 in Kandahar province, Afghanistan, of wounds suffered when enemy forces attacked his vehicle with an improvised explosive device. Specialist Coumas was assigned to 1st Battalion, 17th Infantry Regiment, 5th Stryker Brigade Combat Team, 2nd Infantry Division, Fort Lewis, WA.

Capt Kyle R. Van De Giesen, 29, of North Attleboro, MA, died October 26 while supporting combat operations in Helmand province, Afghanistan. Captain Van De Giesen was assigned to Marine Light Attack Helicopter Squadron 169, Marine Aircraft Group 39, 3rd Marine Aircraft Wing, I Marine Expeditionary Force, Camp Pendleton, CA.

Capt David S. Mitchell, 30, of Loveland, OH, died October 26 while supporting combat operations in Helmand province, Afghanistan. Captain Mitchell was assigned to Marine Light Attack Helicopter Squadron 367, Marine Aircraft Group 39, 3rd Marine Aircraft Wing, I Marine Expeditionary Force, Camp Pendleton, CA.

Capt Eric A. Jones, 29, of Westchester, NY, died October 26 while supporting combat operations in Helmand province, Afghanistan. Captain Jones was assigned to Marine Light Attack Helicopter Squadron 169, Marine Aircraft Group 39, 3rd Marine Aircraft Wing, I Marine Expeditionary Force, Camp Pendleton, CA.

Cpl Gregory M.W. Fleury, 23, of Anchorage, AK, died October 26 while supporting combat operations in Helmand province, Afghanistan. Corporal Fleury was assigned to Marine Light Attack Helicopter Squadron 169, Marine Aircraft Group 39, 3rd Marine Aircraft Wing, I Marine Expeditionary Force, Camp Pendleton, CA.

SGT Eduviges G. Wolf, 24, of Hawthorne, CA, died October 25 in Kunar province, Afghanistan, of wounds suffered when insurgents attacked her vehicle with a rocket-propelled grenade. Sergeant Wolf was assigned to the 704th Brigade Support Battalion, 4th Brigade Combat Team, 4th Infantry Division, Fort Carson, CO.

LCpl Cody R. Stanley, 21, of Rosanky, TX, died October 28 while supporting combat operations in Helmand province, Afghanistan. Lance Corporal Stanley was assigned to 3rd Battalion, 4th Marine Regiment, 1st Marine Division, I Marine Expeditionary Force, Marine Corps Air Ground Combat Center, Twentynine Palms, CA.

SFC David E. Metzger, 32, of San Diego, CA, died October 26 of wounds suffered when the MH–47 helicopter he was aboard crashed in Darreh-ye Bum, Afghanistan. Sergeant First Class Metzger was assigned to the 3rd Battalion, 7th Special Forces Group, Airborne, Fort Bragg, NC.

Sgt Charles I. Cartwright, 26, of Union Bridge, MD, died November 7 while supporting combat operations in Farah province, Afghanistan. Sergeant Cartwright was assigned to 1st Marine Special Operations Battalion, U.S. Marine Corps Forces Special Operations Command, Camp Pendleton, CA.

LCpl Justin J. Swanson, 21, of Anaheim, CA, died November 10 while supporting combat operations in Helmand province, Afghanistan. Lance Corporal Swanson was assigned to 1st Battalion, 5th Marine Regiment, 1st Marine Division, I Marine Expeditionary Force, Camp Pendleton, CA.

PFC Marcus A. Tynes, 19, of Moreno Valley, CA, died November 21 in Kandahar province, Afghanistan, of wounds sustained when enemy forces attacked his vehicle with an improvised explosive device. Private First Class Tynes was assigned to the 2nd Battalion, 508th Parachute Infantry Regiment, 4th Brigade Combat Team, 82nd Airborne Division, Fort Bragg, NC.

COMMITTEE ON AGRICULTURE, NUTRITION AND FORESTRY SUBCOMMITTEE ASSIGNMENTS

Mrs. LINCOLN. Madam President, the Committee on Agriculture, Nutrition and Forestry has amended and adopted subcommittees for the 111th Congress. On behalf of myself and Senator CHAMBLISS, I ask unanimous consent that a copy of the subcommittees be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

UNITED STATES SENATE COMMITTEE ON AGRICULTURE, NUTRITION, AND FORESTRY

111th Congress

SUBCOMMITTEE ASSIGNMENTS

Subcommittee on Rural Revitalization, Conservation, Forestry and Credit: Rural economic revitalization and quality of life; rural job and business growth; rural electrification, telecommunications and utilities; conservation, protection and stewardship of natural resources; state, local and private forests and general forestry; agricultural and rural credit.

Sen. Stabenow, Chair; Sen. Leahy; Sen. Harkin; Sen. Nelson; Sen. Casey; Sen. Bennet; Sen. Cornyn, Ranking; Sen. Cochran; Sen. McConnell; Sen. Grassley; and Sen. Thune.

Subcommittee on Energy, Science and Technology: Renewable energy production and energy efficiency improvement on farms and ranches and in rural communities; food and agricultural research, education, economics and extension; innovation in the use of agricultural commodities and materials.

Sen. Bennet, Chair; Sen. Conrad; Sen. Nelson; Sen. Brown; Sen. Klobuchar; Sen. Stabenow; Sen. Gillibrand; Sen. Thune, Ranking; Sen. Lugar; Sen. Roberts; Sen. Johanns; Sen. Grassley; and Sen. Cornyn.

Subcommittee on Hunger, Nutrition, and Family Farms: Domestic and international nutrition and food assistance and hunger prevention; school and child nutrition programs; local and healthy food initiatives; futures, options and derivatives; pesticides; and general legislation.

Sen. Brown, Chair; Sen. Leahy; Sen. Harkin; Sen. Baucus; Sen. Stabenow; Sen. Casey; Sen. Klobuchar; Sen. Bennet; Sen. Gillibrand; Sen. Lugar, Ranking; Sen. Cochran; Sen. McConnell; and Sen. Cornyn.

Subcommittee on Production, Income Protection and Price Support: Production of agricultural crops, commodities and products; farm and ranch income protection and assistance; commodity price support programs; insurance and risk protection; fresh water food production.

Sen. Casey, Chair; Sen. Leahy; Sen. Harkin; Sen. Conrad; Sen. Baucus; Sen. Brown; Sen. Roberts, Ranking; Sen. Cochran; Sen. Johanns; Sen. Grassley; and Sen. Thune.

Subcommittee on Domestic and Foreign Marketing, Inspection, and Plant and Animal Health: Agricultural trade; foreign market development; domestic marketing and product promotion; marketing orders and regulation of agricultural markets and animal welfare; inspection and certification of plants, animals and products; plant and animal diseases and health protection.

Sen. Gillibrand, Chair; Sen. Conrad; Sen. Baucus; Sen. Nelson; Sen. Klobuchar; Sen. Johanns, Ranking; Sen. Lugar; Sen. McConnell; and Sen. Roberts.

*Senator Lincoln and Senator Chambliss serve as ex officio members of all subcommittees.

ADDITIONAL STATEMENTS

TRIBUTE TO CANADIAN SENATOR JERAHMIEL ''JERRY'' GRAFSTEIN

● Mr. CARDIN. Madam President, I wish to draw the attention of my colleagues to the retirement of Jerahmiel S. Grafstein from the Canadian Senate.

As a member and now as Chairman of the Helsinki Commission, I have had the privilege to know and work with Jerry Grafstein over the years through participation in the Parliamentary Assembly of the Organization for Security and Cooperation in Europe—the OSCE. I know that my colleague from Ohio, Senator VOINOVICH, also knows Jerry well, having just worked with him on a resolution at this year's Annual Session of the Assembly in Vilnius, Lithuania, on combating anti-Semitism. I suspect that many of my other Senate colleagues have also worked with him over the years, as have many of our colleagues in the House of Representatives.

Anybody who has met Senator Grafstein immediately recognizes him as a man of tremendous energy, deep commitment and brilliant mind. Commenting on Jerry's career, one of his Canadian Senate colleagues noted the daunting task of paying tribute ''to a force of nature disguised as a person.'' A successful lawyer, businessman and member of the Liberal Party, he was summoned to the Canadian Senate in 1984. Jerry Grafstein's accomplishments over the next 25 years of public service are much more than I can relay here.

I do, however, want to highlight Jerry's prominent work with the 56 countries, 300 member OSCE Parliamentary Assembly. Serving for 6 years as the Assembly's treasurer and then, with me since 2007, as one of nine Vice Presidents, Jerry has understood the potential of this multilateral parliamentary forum to promote human rights, democracy and tolerance. Such a vital forum, however, does not just magically appear for the world's benefit. Someone has to take the time to make it function by participating as an officer, attending countless organizational meetings and, for us and our Canadian neighbors, traveling frequently across the Atlantic to do so. Jerry was one who rose to the challenge and then some.

Even as he helped on organizational matters, Jerry Grafstein found more time than most others to focus on substance. First and foremost, he has helped to lead the charge against rising anti-Semitism across Europe and around the world. Diplomacy has a tendency to soften the criticism and downplay the negative, often until it is too late, but Jerry has helped to ensure that the OSCE did not shy away from dealing directly with this and other manifestations of hate and prejudice that dangerously confront far too many societies. Today, thanks to the vigilance of Jerry Grafstein and others, efforts to promote greater tolerance are now a solid, ongoing and vital aspect of the OSCE's work.

This distinguished Senator from Canada also found time to participate and help lead OSCE PA missions observing elections and referenda in places like Russia, Ukraine, Georgia and Montenegro. By being an international observer, he became a witness to history and, in my view, helped history forward and make the world a more democratic place.

In all his public endeavors, Jerry Grafstein has been a close friend of the United States of America. He has helped over the years to develop the bilateral dialogue between the U.S. Congress and the Canadian Parliament. He has come here to Washington on many occasions, including as a participant in Helsinki Commission events. He has always made clear that he is Canadian and proud of the country he represents, but that has never kept him from developing areas of common interest and seeking points of agreement even on some issues where our national views may otherwise diverge.

Jerry Grafstein has been and will remain a close personal friend as well, always concerned, always engaging, never pretentious. I wish him and his wife Carole the very best. Although he deserves some time off, I am confident that he will remain prominent in the life of the vibrant city of Toronto.

In noting the many accomplishments of Jerahmiel Grafstein and thanking him for his commitment to public service, I respectfully borrow the Canadian Senate's tradition and join his colleagues in saying: ''Hear, Hear!'' On a personal level, I believe I speak for numerous colleagues of my own in saying that Jerry will be missed, and always welcome to come and visit.●

TRIBUTE TO TOMÁS VILLANUEVA

● Mrs. MURRAY. Madam President, today I would like to take a moment to recognize a very special advocate, activist, and champion for equal rights in my home State of Washington on his birthday.

Tomás Villanueva has been a farmworkers, warehouse packers, and other economically disadvantaged laborers advocate since the early 1960s. Tomás was one of the first people involved in the United Farmworkers Union in my home State and has fought for years to ensure that workers are treated with dignity, respect, and under the protections of the law.

Tomás' involvement with the human rights movement began in the early 1960s when he was inspired by UFW leader Cesar Chavez. And since that time, Tomás has fought for numerous causes and people while maintaining his reputation as a kind, generous, compassionate and humble leader.

Tomás has also been a close friend and partner of mine for a very long time. He has helped my staff and I recognize the depth of the difficult conditions that farmworkers face, and has been a consistent voice in fighting to improve conditions through the legislative process.

Farmworker housing is a moral issue, an economic issue, and a family issue. Too many workers and their families face very difficult living conditions. Some live in their cars. Others share run-down, overcrowded rooms with other families. These are not the kinds of living conditions we can tolerate in the United States in the 21st century. They are certainly not suitable for the people who help put food on our tables and who keep our State's economy strong. Tomás knows that we can and must do better.

Tomás Villanueva was 14 when his family emigrated from Mexico. After following the crops for three years, the family settled in Toppenish, Washington in 1958. Tomás spent the next several years working various jobs before earning a high school GED and enrolling in Yakima Valley College.

Hearing about Caesar Chavez's United Farm Workers movement, Tomás travelled to California in 1967 to learn about organizing. Returning to the Yakima Valley, he helped found the United Farm Worker Cooperative, one of the very first Chicano organizations in the State of Washington.

From 1967 to 1974, Tomás devoted himself to farm worker organizing and Chicano movement activism. Out of these efforts came the Yakima Valley Farmworkers Clinic, the United Farm Workers Service Center, a wave of hop harvest strikes in 1969, 1970, 1971, and a successful grape boycott.

In 1974, Tomás started a construction company with his father and brothers, but in the 1980s he was back in the union movement. In 1986 he became the first president of the newly formed United Farm Workers of Washington State. Today he lives in Toppenish and remains active in State and local politics.

Tomás Villanueva continues to be a valued friend, hard-working partner, and widely-respected leader in his community. I am so pleased to recognize his lifetime of achievements on this special day.●

RECOGNIZING SUTHERLAND WESTON MARKETING COMMUNICATIONS

● Ms. SNOWE. Madam President, as we approach the holiday season, we are frequently reminded of the generosity and warmth that Americans demonstrate year in and year out at this most festive time. In particular, we often hear stories of employees at local businesses who graciously donate their time and efforts to help the less fortunate. This week I wish to recognize the employees of one such company who consistently work to improve the lot of everyone in their community.

Sutherland Weston Marketing Communications of Bangor is a cutting-edge firm that specializes in a host of marketing topics, including public relations, media, and branding. Specifically, the company helps its customers design memorable flyers and mailers, effective television advertisements, and state-of-the-art Web sites, and teaches them the increased value of employing popular social media, such as Facebook and Twitter, in their marketing decisions. Since its inception in 2005, Sutherland Weston has assisted dozens of clients throughout Maine seeking ways to enhance their image and broaden their customer base. Among them are local small businesses such as Maine Wood Concepts of Guilford and Raye's Mustard Mill of Eastport; organizations like the Bangor Symphony Orchestra; and institutions such as the University of Maine.

Furthermore, members of the Sutherland Weston team participate regularly in conferences and seminars to better educate the public on how to maximize marketing strategies. One such event is the Social Media 101 seminar, held this past March, where the firm's owners—Elizabeth Sutherland

and Cary Weston—presented a workshop designed at increasing the professional use of sites such as Facebook, Twitter, and LinkedIn.

The nine employees of Sutherland Weston are also active members of the greater Bangor community, contributing to various philanthropic endeavors on a regular basis. This past June, the company took part in the 25th Trek Across Maine in support of the American Lung Association. The ''Green Marketeers,'' including Sutherland Weston employees, spouses, and friends, took to their bicycles for the 180-mile trip from Bethel's Sunday River mountain to the coastal town of Belfast, raising nearly $8,000 in pledges along the way.

Additionally, in recognition of the true meaning of Christmas, the company's employees donated time and talent this year to creating a new, user-friendly Web site called Christmas is for Kids, a critical program that facilitates donations of holiday gifts for underprivileged children across Maine. The Web site allows users to find the name and hometown of a child, as well as the specific gift he or she is requesting, adding a personal touch to the experience. Donors indicate which gift they are willing to purchase so that it can be removed from the listing, doing their best to ensure that no child is left out. Several sponsors have suggested that because of Sutherland Weston's noteworthy Web site, 2009 may be the most successful season in the program's 27-year history.

As we look forward to celebrating the upcoming holidays with our loved ones, let us take a moment to remember those experiencing sorrow during this joyous season. And let us also recognize those who are working in every community across the country to make someone's day brighter through deeds great and small. I thank Elizabeth Sutherland, Cary Weston, and everyone at Sutherland Weston Marketing Communications for their selfless gift this holiday season, and wish them continued success in their future endeavors.●

MESSAGES FROM THE HOUSE

At 11:49 a.m., a message from the House of Representatives, delivered by Ms. Niland, one of its reading clerks, announced that the House has passed the following bills, in which it requests the concurrence of the Senate:

H.R. 1084. An act to require the Federal Communications Commission to prescribe a standard to preclude commercials from being broadcast at louder volumes than the program material they accompany.

H.R. 1517. An act to allow certain U.S. Customs and Border Protection employees who serve under an overseas limited appointment for at least 2 years, and whose service is rated fully successful or higher throughout that time, to be converted to a permanent appointment in the competitive service.

H.R. 2194. An act to amend the Iran Sanctions Act of 1996 to enhance United States diplomatic efforts with respect to Iran by expanding economic sanctions against Iran.

H.R. 3978. An act to amend the Implementing Recommendations of the 9/11 Commission Act of 2007 to authorize the Secretary of Homeland Security to accept and use gifts for otherwise authorized activities of the Center for Domestic Preparedness that are related to preparedness for and response to terrorism, and for other purposes.

The message also announced that the House has passed the following bill, without amendment:

S. 1472. An act to establish a section within the Criminal Division of the Department of Justice to enforce human rights laws, to make technical and conforming amendments to criminal and immigration laws pertaining to human rights violations, and for other purposes.

The message further announced that the House has agreed to the following concurrent resolution:

H. Con. Res. 223. Concurrent resolution providing for the sine die adjournment of the first session of the One Hundred Eleventh Congress.

At 2:10 p.m., a message from the House of Representatives, delivered by Mrs. Cole, one of its reading clerks, announced that the House agreed to the amendment of the Senate to the bill (H.R. 3326) making appropriations for the Department of Defense for the fiscal year ending September 30, 2010, and for other purposes; with an amendment, in which it requests the concurrence of the Senate.

At 5:29 p.m., a message from the House of Representatives, delivered by Ms. Niland, one of its reading clerks, announced that the House has passed the following bills, in which it requests the concurrence of the Senate:

H.R. 1110. An act to amend title 18, United States Code, to prevent caller ID spoofing, and for other purposes.

H.R. 4314. An act to permit continued financing of Government operations.

H.J. Res. 64. Joint resolution making further continuing appropriations for fiscal year 2010, and for other purposes.

The message also announced that the House has agreed to the following concurrent resolution, in which it requests the concurrence of the Senate:

H. Con Res. 160. Concurrent resolution recognizing the contributions of the American Kennel Club.

MEASURES REFERRED

The following bills were read the first and the second times by unanimous consent, and referred as indicated:

H.R. 1084. An act to require the Federal Communications Commission to prescribe a standard to preclude commercials from being broadcast at louder volumes than the program material they accompany; to the Committee on Commerce, Science, and Transportation.

H.R. 1110. An act to amend title 18, United States Code, to prevent caller ID spoofing, and for other purposes; to the Committee on the Judiciary.

H.R. 1517. An act to allow certain U.S. Customs and Border Protection employees who serve under an overseas limited appointment for at least 2 years, and whose service is rated fully successful or higher throughout that time, to be converted to a permanent appointment in the competitive service; to the Committee on Homeland Security and Governmental Affairs.

H.R. 2194. An act to amend the Iran Sanctions Act of 1996 to enhance United States diplomatic efforts with respect to Iran by expanding economic sanctions against Iran; to the Committee on Banking, Housing, and Urban Affairs.

H.R. 3978. An act to amend the Implementing Recommendations of the 9/11 Commission Act of 2007 to authorize the Secretary of Homeland Security to accept and use gifts for otherwise authorized activities of the Center for Domestic Preparedness that are related to preparedness for and response to terrorism, and for other purposes; to the Committee on Homeland Security and Governmental Affairs.

The following concurrent resolution was read, and referred as indicated:

H. Con. Res. 160. Concurrent resolution honoring the American Kennel Club; to the Committee on the Judiciary.

EXECUTIVE AND OTHER COMMUNICATIONS

The following communications were laid before the Senate, together with accompanying papers, reports, and documents, and were referred as indicated:

EC–4057. A communication from the Acting Administrator, Risk Management Agency, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled ''Common Crop Insurance Regulations; Basic Provision'' ((7 CFR Part 457 (RIN0563–AC23)) received in the Office of the President of the Senate on December 8, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC–4058. A communication from the Acting Farm Bill Coordinator, Commodity Credit Corporation, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled ''Agricultural Management Assistance Program'' (RIN0578–AA50) received in the Office of the President of the Senate on December 14, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC–4059. A communication from the Acting Farm Bill Coordinator, Commodity Credit Corporation, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled ''Regional Equity'' (RIN0578–AA44) received in the Office of the President of the Senate on December 14, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC–4060. A communication from the Administrator, Fruit and Vegetable Programs, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled ''Potato Research and Promotion Plan; Assessment Increase'' (Docket No. AMS–FV–09–0024; FV–09–706FR) received in the Office of the President of the Senate on December 14, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC–4061. A communication from the Administrator, Fruit and Vegetable Programs, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled ''Vegetable Import Regulations; Modification of Potato Import Regulations'' (Docket No. AMS–FV–08–0018; FV08–980–1 FR) received in the Office of the President of the Senate on December 14, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC–4062. A communication from the Regulatory Officer, Foreign Agricultural Service, Department of Agriculture, transmitting,

pursuant to law, the report of a rule entitled ''McGovern Dole International Food for Education and Child Nutrition Program and Food for Progress Program'' (RIN0551–AA78) received in the Office of the President of the Senate on December 9, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC–4063. A communication from the Regulatory Officer, Foreign Agricultural Service, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled ''Adjustment of Appendices to the Dairy Tariff-Rate Import Quota Licensing Regulation for the 2009 Tariff-Rate Quota Year'' (7 CFR Part 6) received in the Office of the President of the Senate on December 9, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC–4064. A communication from the Regulatory Officer, Foreign Agricultural Service, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled ''Technical Assistance for Specialty Crops'' (RIN0551–AA71) received in the Office of the President of the Senate on December 9, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC–4065. A communication from the Chief of the Publications and Regulations Branch, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Section 807(e)(4) Exception for Section 338 Regulations'' (Notice No. 2010–1) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Finance.

EC–4066. A communication from the Chief of the Publications and Regulations Branch, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Remedial Amendment Period and Reliance for Section 403(b) Plans'' (Announcement 2009–89) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Finance.

EC–4067. A communication from the Chief of the Publications and Regulations Branch, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Interim Guidance on Interactions with Foreign Tax Officials'' (LMSB–4–0409–013) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Finance.

EC–4068. A communication from the Chief of the Publications and Regulations Branch, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Revenue Ruling: 94X Examples'' (Rev. Rul. 2009–39) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Finance.

EC–4069. A communication from the Chief of the Publications and Regulations Branch, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Production Tax Credits for Refined Coal'' (Notice No. 2009–90) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Finance.

EC–4070. A communication from the Chief of the Publications and Regulations Branch, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''2009 Base Period T-Bill Rate'' (Rev. Rul. 2009–36) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Finance.

EC–4071. A communication from the Chief of the Publications and Regulations Branch, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Update of Weighted Average Interest Rates, Yield Curves, and Segment Rates'' (Notice 2009–96) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Finance.

EC–4072. A communication from the Chief of the Publications and Regulations Branch, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Salvage Discount Factors for 2009'' (Rev. Proc. 2009–56) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Finance.

EC–4073. A communication from the Chief of the Publications and Regulations Branch, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''2010 Standard Mileage Rates'' (Rev. Proc. 2009–54) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Finance.

EC–4074. A communication from the Chief of the Publications and Regulations Branch, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Extension of Attributed Tip Income Program (ATIP)'' (Rev. Proc. 2009–53) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Finance.

EC–4075. A communication from the Chairman of the Securities and Exchange Commission, transmitting, pursuant to law, a report entitled ''2008 Annual Report of the Securities Investor Protection Corporation''; to the Committee on Banking, Housing, and Urban Affairs.

EC–4076. A communication from the Acting Assistant Secretary for Export Administration, Bureau of Industry and Security, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled ''Implementation of the Wassenaar Arrangement's (WA) Task Force on Editorial Issues (TFEI) Revisions'' (RIN0694–AE71) received in the Office of the President of the Senate on December 4, 2009; to the Committee on Banking, Housing, and Urban Affairs.

EC–4077. A communication from the Assistant to the Board of Governors, Federal Reserve System, transmitting, pursuant to law, the report of a rule entitled ''Risk-Based Capital Guidelines; Capital Adequacy Guidelines; Capital Maintenance; Capital—Residential Mortgage Loans Modified Pursuant to the Home Affordable Mortgage Program'' (Docket No. R–1361) received in the Office of the President of the Senate on December 4, 2009; to the Committee on Banking, Housing, and Urban Affairs.

EC–4078. A communication from the Assistant to the Board of Governors, Federal Reserve System, transmitting, pursuant to law, the report of a rule entitled ''Risk-Based Capital Guidelines; Capital Adequacy Guidelines; Capital Maintenance; Capital—Residential Mortgage Loans Modified Pursuant to the Home Affordable Mortgage Program'' (RIN1550–AC34) received in the Office of the President of the Senate on December 9, 2009; to the Committee on Banking, Housing, and Urban Affairs.

EC–4079. A communication from the Legal Information Assistant, Office of Thrift Supervision, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Final Model Privacy Form Under the Gramm-Leach-Bliley Act'' (RIN1550–AC12) received in the Office of the President of the Senate on December 9, 2009; to the Committee on Banking, Housing, and Urban Affairs.

EC–4080. A communication from the Deputy to the Chairman for External Affairs, Federal Deposit Insurance Corporation, transmitting, pursuant to law, the report of a rule entitled ''Interest on Deposits'' (RIN3064–AD46) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Banking, Housing, and Urban Affairs.

EC–4081. A communication from the Deputy to the Chairman for External Affairs, Federal Deposit Insurance Corporation, transmitting, pursuant to law, the report of a rule entitled ''Risk-Based Capital Guidelines; Capital Adequacy Guidelines; Capital Maintenance; Capital—Residential Mortgage Loans Modified Pursuant to the Home Affordable Mortgage Program'' (RIN3064–AD42) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Banking, Housing, and Urban Affairs.

EC–4082. A communication from the Director, Minerals Management Service, Department of the Interior, transmitting, pursuant to law, a report entitled ''Report to Congress: Minerals Management Service Royalty in Kind Operation Program'' for Fiscal Year 2008; to the Committee on Energy and Natural Resources.

EC–4083. A communication from the Assistant General Counsel for Legislation, Regulation and Energy Efficiency, Department of Energy, transmitting, pursuant to law, the report of a rule entitled ''Loan Guarantees for Projects That Employ Innovative Technologies'' (RIN1901–AB27) received in the Office of the President of the Senate on December 8, 2009; to the Committee on Energy and Natural Resources.

EC–4084. A communication from the Division Chief of Regulatory Affairs, Bureau of Land Management, Department of the Interior, transmitting, pursuant to law, the report of a rule entitled ''Oil and Gas Leasing; National Petroleum Reserve, Alaska'' (RIN1004–AD87) received in the Office of the President of the Senate on December 9, 2009; to the Committee on Energy and Natural Resources.

EC–4085. A communication from the General Counsel, Federal Energy Regulatory Commission, transmitting, pursuant to law, the report of a rule entitled ''Mandatory Reliability Standards for the Calculation of Available Transfer Capability, Capacity Benefit Margins, Transmission Reliability Margins, Total Transfer Capability, and Existing Transmission Commitments and Mandatory Reliability Standards for the Bulk-Power System'' (Docket Nos. RM08–19–000, RM08–19–001, RM09–5–000, RM06–16–005) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Energy and Natural Resources.

EC–4086. A communication from the Director of Congressional Affairs, Office of Administration, Nuclear Regulatory Commission, transmitting, pursuant to law, the report of a rule entitled ''Administrative Changes: Clarification of the Location of Guidance for Electronic Submission and other Miscellaneous Corrections'' (RIN3150–AI73) received in the Office of the President of the Senate on December 9, 2009; to the Committee on Environment and Public Works.

EC–4087. A communication from the Deputy Assistant Administrator, Bureau for Legislative and Public Affairs, U.S. Agency for International Development, transmitting, pursuant to law, the Agency's response to the GAO report entitled ''Rebuilding IRAQ: Improved Management Controls and Iraqi Commitment Needed for Key State and USAID Capacity-Building Programs''; to the Committee on Foreign Relations.

EC–4088. A communication from the Assistant Secretary, Bureau of Legislative Affairs, Department of State, transmitting, pursuant to law, the report of a rule entitled ''Visas: Documentation of Immigrants and Nonimmigrants-Visa Classification Symbols'' received in the Office of the President of the

Senate on December 9, 2009; to the Committee on Foreign Relations.

EC–4089. A communication from the Deputy Director of Regulations and Policy Management Staff, Food and Drug Administration, Department of Health and Human Services, transmitting, pursuant to law, the report of a rule entitled ''Organ-Specific Warnings; Antipyretic, and Antirheumatic Drug Products for Over-the-Counter Human Use; Final Monograph; Technical Amendment'' (Docket No. FDA–1977–N–0013) received in the Office of the President of the Senate on December 9, 2009; to the Committee on Health, Education, Labor, and Pensions.

EC–4090. A communication from the Assistant General Counsel for Regulatory Services, Office of Elementary and Secondary Education, Department of Education, transmitting, pursuant to law, the report of a rule entitled ''State Fiscal Stabilization Fund Program'' (RIN1810–AB04) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Health, Education, Labor, and Pensions.

EC–4091. A communication from the Director of Regulations and Rulings, Alcohol and Tobacco Tax and Trade Bureau, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Establishment of the Calistoga Viticultural Area (2003R–496P)'' (RIN1513–AA92) received in the Office of the President of the Senate on December 10, 2009; to the Committee on the Judiciary.

EC–4092. A communication from the Staff Director, United States Commission on Civil Rights, transmitting, pursuant to law, the report of the appointment of members to the Massachusetts Advisory Committee; to the Committee on the Judiciary.

EC–4093. A communication from the Principal Deputy Assistant Attorney General, Office of Legislative Affairs, Department of Justice, transmitting, pursuant to law, a report entitled ''Report to the Nation 2009''; to the Committee on the Judiciary.

EC–4094. A communication from the National Executive Secretary, Navy Club of the United States of America, transmitting, pursuant to law, a report relative to the national financial statement of the organization and national staff and convention minutes for the year ending July 31, 2009; to the Committee on the Judiciary.

EC–4095. A communication from the Chairman of the National Transportation Safety Board, transmitting, pursuant to law, the report of a rule entitled ''Notification and Reporting of Aircraft Accidents or Incidents and Overdue Aircraft, and Preservation of Aircraft Wreckage, Mail, Cargo, and Records'' received in the Office of the President of the Senate on December 10, 2009; to the Committee on Commerce, Science, and Transportation.

EC–4096. A communication from the Deputy Chief Counsel of the Office of Regulations and Security Standards, Transportation Security Administration, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled ''False Statements Regarding Security Background Checks'' (RIN1652–AA65) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Commerce, Science, and Transportation.

EC–4097. A communication from the Trial Attorney, Federal Railroad Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled ''Adjustment of the Monetary Threshold for Reporting Rail Equipment Accidents/Incidents for Calendar Year 2010'' (RIN2130–ZA02) received in the Office of the President of the Senate on December 10, 2009; to the Committee on Commerce, Science, and Transportation.

REPORTS OF COMMITTEES

The following reports of committees were submitted:

By Mr. INOUYE, from the Committee on Appropriations:

Special Report entitled ''Further Revised Allocation to Subcommittees of Budget Totals From the Concurrent Resolution, Fiscal Year 2010.'' (Rept. No. 111–109).

By Mrs. LINCOLN, from the Committee on Agriculture, Nutrition, and Forestry, without amendment:

H.R. 310. A bill to provide for the conveyance of approximately 140 acres of land in the Ouachita National Forest in Oklahoma to the Indian Nations Council, Inc., of the Boy Scouts of America, and for other purposes.

H.R. 511. A bill to authorize the Secretary of Agriculture to terminate certain easements held by the Secretary on land owned by the Village of Caseyville, Illinois, and to terminate associated contractual arrangements with the Village.

By Mrs. LINCOLN, from the Committee on Agriculture, Nutrition, and Forestry, without amendment and with a preamble:

S. Res. 374. A resolution recognizing the cooperative efforts of hunters, sportsmen's associations, meat processors, hunger relief organizations, and State wildlife, health, and food safety agencies to establish programs that provide game meat to feed the hungry.

By Mr. BINGAMAN, from the Committee on Energy and Natural Resources, without amendment:

S. 1672. A bill to reauthorize the National Oilheat Research Alliance Act of 2000.

By Mr. DORGAN, from the Committee on Indian Affairs, with amendments:

S. 1790. A bill to amend the Indian Health Care Improvement Act to revise and extend that Act, and for other purposes.

EXECUTIVE REPORTS OF COMMITTEES

The following executive reports of nominations were submitted:

By Mrs. LINCOLN for the Committee on Agriculture, Nutrition, and Forestry.

*Jill Long Thompson, of Indiana, to be a Member of the Farm Credit Administration Board, Farm Credit Administration, for a term expiring May 21, 2014.

By Mr. LIEBERMAN for the Committee on Homeland Security and Governmental Affairs.

*Elizabeth M. Harman, of Maryland, to be an Assistant Administrator of the Federal Emergency Management Agency, Department of Homeland Security.

*Grayling Grant Williams, of Maryland, to be Director of the Office of Counternarcotics Enforcement, Department of Homeland Security.

By Mr. AKAKA for the Committee on Veterans' Affairs.

*Robert A. Petzel, of Minnesota, to be Under Secretary for Health of the Department of Veterans Affairs.

*Nomination was reported with recommendation that it be confirmed subject to the nominee's commitment to respond to requests to appear and testify before any duly constituted committee of the Senate.

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second times by unanimous consent, and referred as indicated:

By Ms. LANDRIEU (for herself and Ms. KLOBUCHAR):

S. 2885. A bill to amend the Omnibus Crime Control and Safe Streets Act of 1968 to provide adequate benefits for public safety officers injured or killed in the line of duty, and for other purposes; to the Committee on the Judiciary.

By Ms. CANTWELL (for herself, Mr. MCCAIN, and Mr. FEINGOLD):

S. 2886. A bill to prohibit certain affiliations (between commercial banking and investment banking companies), and for other purposes; to the Committee on Banking, Housing, and Urban Affairs.

By Mrs. MURRAY:

S. 2887. A bill to amend title V of the Elementary and Secondary Education Act of 1965 to reduce class size through the use of highly qualified teachers, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

By Mr. CARDIN:

S. 2888. A bill to amend section 205 of title 18, United States Code, to exempt qualifying law school students participating in legal clinics from the application of the general conflict of interest rules under such section; to the Committee on the Judiciary.

By Mr. ROCKEFELLER (for himself, Mrs. HUTCHISON, Mr. LAUTENBERG, Mr. THUNE, and Mr. DORGAN):

S. 2889. A bill to reauthorize the Surface Transportation Board, and for other purposes; to the Committee on Commerce, Science, and Transportation.

By Mr. FEINGOLD:

S. 2890. A bill to amend the Buy American Act to increase the requirement for American-made content, to tighten the waiver provisions, and for other purposes; to the Committee on Homeland Security and Governmental Affairs.

By Mr. REID (for himself, Mr. ENSIGN, Mrs. FEINSTEIN, and Mrs. BOXER):

S. 2891. A bill to further allocate and expand the availability of hydroelectric power generated at Hoover Dam, and for other purposes; to the Committee on Energy and Natural Resources.

By Mr. SHELBY (for himself and Mr. SESSIONS):

S. 2892. A bill to establish the Alabama Black Belt National Heritage Area, and for other purposes; to the Committee on Energy and Natural Resources.

By Mr. SCHUMER:

S. 2893. A bill to amend the Controlled Substances Import and Export Act to prevent the use of Indian reservations located on the United States borders to facilitate cross—border drug trafficking, and for other purposes; to the Committee on the Judiciary.

By Mrs. GILLIBRAND:

S. 2894. A bill to amend the Internal Revenue Code to provide for a refundable tax credit for heating fuels and to create a grant program for States to provide individuals with loans to weatherize their homes; to the Committee on Finance.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Mr. INOUYE (for himself, Mr. GREGG, Mr. LIEBERMAN, and Mr. DURBIN):

S. Res. 376. A resolution honoring the 60th anniversary of the establishment of diplomatic relations between the United States and the Hashemite Kingdom of Jordan, the

10th anniversary of the accession to the throne of His Majesty King Abdullah II Ibn Al Hussein, and for other purposes; considered and agreed to.

By Mr. MENENDEZ:

S. Con. Res. 48. A concurrent resolution recognizing the leadership and historical contributions of Dr. Hector Garcia to the Hispanic community and his remarkable efforts to combat racial and ethnic discrimination in the United States of America; to the Committee on the Judiciary.

ADDITIONAL COSPONSORS

S. 678

At the request of Mr. LEAHY, the name of the Senator from Minnesota (Mr. FRANKEN) was added as a cosponsor of S. 678, a bill to reauthorize and improve the Juvenile Justice and Delinquency Prevention Act of 1974, and for other purposes.

S. 777

At the request of Mr. BROWN, the name of the Senator from Michigan (Ms. STABENOW) was added as a cosponsor of S. 777, a bill to promote industry growth and competitiveness and to improve worker training, retention, and advancement, and for other purposes.

S. 1055

At the request of Mrs. BOXER, the name of the Senator from South Dakota (Mr. JOHNSON) was added as a cosponsor of S. 1055, a bill to grant the congressional gold medal, collectively, to the 100th Infantry Battalion and the 442nd Regimental Combat Team, United States Army, in recognition of their dedicated service during World War II.

S. 1067

At the request of Mr. BROWNBACK, the name of the Senator from California (Mrs. FEINSTEIN) was withdrawn as a cosponsor of S. 1067, a bill to support stabilization and lasting peace in northern Uganda and areas affected by the Lord's Resistance Army through development of a regional strategy to support multilateral efforts to successfully protect civilians and eliminate the threat posed by the Lord's Resistance Army and to authorize funds for humanitarian relief and reconstruction, reconciliation, and transitional justice, and for other purposes.

S. 1204

At the request of Mrs. MURRAY, the name of the Senator from Alaska (Mr. BEGICH) was added as a cosponsor of S. 1204, a bill to amend the Department of Veterans Affairs Health Care Programs Enhancement Act of 2001 to require the provision of chiropractic care and services to veterans at all Department of Veterans Affairs medical centers, and for other purposes.

S. 1492

At the request of Mr. BENNET, his name was added as a cosponsor of S. 1492, a bill to amend the Public Health Service Act to fund breakthroughs in Alzheimer's disease research while providing more help to caregivers and increasing public education about prevention.

S. 1524

At the request of Mr. KERRY, the name of the Senator from Maine (Ms. COLLINS) was added as a cosponsor of S. 1524, a bill to strengthen the capacity, transparency, and accountability of United States foreign assistance programs to effectively adapt and respond to new challenges of the 21st century, and for other purposes.

S. 1743

At the request of Mrs. LINCOLN, the name of the Senator from Louisiana (Ms. LANDRIEU) was added as a cosponsor of S. 1743, a bill to amend the Internal Revenue Code of 1986 to expand the rehabilitation credit, and for other purposes.

S. 1809

At the request of Mr. WICKER, the name of the Senator from Mississippi (Mr. COCHRAN) was added as a cosponsor of S. 1809, a bill to amend the Clean Air Act to promote the certification of aftermarket conversion systems and thereby encourage the increased use of alternative fueled vehicles.

S. 1859

At the request of Mr. ROCKEFELLER, the name of the Senator from Ohio (Mr. BROWN) was added as a cosponsor of S. 1859, a bill to reinstate Federal matching of State spending of child support incentive payments.

S. 2052

At the request of Mr. UDALL of Colorado, the names of the Senator from Louisiana (Ms. LANDRIEU) and the Senator from Idaho (Mr. RISCH) were added as cosponsors of S. 2052, a bill to amend the Energy Policy Act of 2005 to require the Secretary of Energy to carry out a research and development and demonstration program to reduce manufacturing and construction costs relating to nuclear reactors, and for other purposes.

S. 2129

At the request of Ms. COLLINS, the name of the Senator from Hawaii (Mr. AKAKA) was added as a cosponsor of S. 2129, a bill to authorize the Administrator of General Services to convey a parcel of real property in the District of Columbia to provide for the establishment of a National Women's History Museum.

S. 2847

At the request of Mr. WHITEHOUSE, the name of the Senator from Washington (Mrs. MURRAY) was added as a cosponsor of S. 2847, a bill to regulate the volume of audio on commercials.

S. 2852

At the request of Mr. BEGICH, the name of the Senator from Texas (Mrs. HUTCHISON) was added as a cosponsor of S. 2852, a bill to establish, within the National Oceanic and Atmospheric Administration, an integrated and comprehensive ocean, coastal, Great Lakes, and atmospheric research, prediction, and environmental information program to support renewable energy.

S. 2853

At the request of Mr. GREGG, the name of the Senator from Alaska (Ms. MURKOWSKI) was added as a cosponsor of S. 2853, a bill to establish a Bipartisan Task Force for Responsible Fiscal Action, to assure the long-term fiscal stability and economic security of the Federal Government of the United States, and to expand future prosperity growth for all Americans.

S. 2859

At the request of Mr. INOUYE, the name of the Senator from Florida (Mr. LEMIEUX) was added as a cosponsor of S. 2859, a bill to reauthorize the Coral Reef Conservation Act of 2000, and for other purposes.

S. 2862

At the request of Ms. SNOWE, the name of the Senator from Indiana (Mr. BAYH) was added as a cosponsor of S. 2862, a bill to amend the Small Business Act to improve the Office of International Trade, and for other purposes.

S. 2869

At the request of Ms. LANDRIEU, the names of the Senator from Indiana (Mr. BAYH), the Senator from Georgia (Mr. ISAKSON) and the Senator from California (Mrs. FEINSTEIN) were added as cosponsors of S. 2869, a bill to increase loan limits for small business concerns, to provide for low interest refinancing for small business concerns, and for other purposes.

S. 2871

At the request of Mr. INOUYE, the name of the Senator from Oregon (Mr. WYDEN) was added as a cosponsor of S. 2871, a bill to make technical corrections to the Western and Central Pacific Fisheries Convention Implementation Act, and for other purposes.

S. RES. 374

At the request of Mrs. LINCOLN, the name of the Senator from Michigan (Ms. STABENOW) was added as a cosponsor of S. Res. 374, a resolution recognizing the cooperative efforts of hunters, sportsmen's associations, meat processors, hunger relief organizations, and State wildlife, health, and food safety agencies to establish programs that provide game meat to feed the hungry.

AMENDMENT NO. 2790

At the request of Mr. CASEY, the name of the Senator from Illinois (Mr. DURBIN) was added as a cosponsor of amendment No. 2790 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2866

At the request of Mr. SPECTER, the name of the Senator from Colorado (Mr. UDALL) was added as a cosponsor of amendment No. 2866 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2938

At the request of Mrs. GILLIBRAND, the name of the Senator from Hawaii

(Mr. AKAKA) was added as a cosponsor of amendment No. 2938 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2976

At the request of Mr. CARDIN, the name of the Senator from South Dakota (Mr. JOHNSON) was added as a cosponsor of amendment No. 2976 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2993

At the request of Mr. SCHUMER, the name of the Senator from Indiana (Mr. BAYH) was added as a cosponsor of amendment No. 2993 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 2997

At the request of Ms. KLOBUCHAR, the name of the Senator from Maryland (Ms. MIKULSKI) was added as a cosponsor of amendment No. 2997 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 3073

At the request of Mrs. FEINSTEIN, the name of the Senator from New York (Mrs. GILLIBRAND) was added as a cosponsor of amendment No. 3073 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 3085

At the request of Mrs. LINCOLN, the name of the Senator from California (Mrs. BOXER) was added as a cosponsor of amendment No. 3085 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 3136

At the request of Mr. UDALL of New Mexico, the name of the Senator from South Dakota (Mr. JOHNSON) was added as a cosponsor of amendment No. 3136 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 3227

At the request of Mr. CARDIN, the name of the Senator from Maryland (Ms. MIKULSKI) was added as a cosponsor of amendment No. 3227 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 3228

At the request of Ms. LANDRIEU, the names of the Senator from New York (Mrs. GILLIBRAND) and the Senator from Pennsylvania (Mr. SPECTER) were added as cosponsors of amendment No. 3228 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENT NO. 3241

At the request of Mr. CARPER, the name of the Senator from New Hampshire (Mr. GREGG) was added as a cosponsor of amendment No. 3241 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Ms. CANTWELL (for herself, Mr. MCCAIN, and Mr. FEINGOLD):

S. 2886. A bill to prohibit certain affiliations (between commercial banking and investment banking companies), and for other purposes; to the Committee on Banking, Housing, and Urban Affairs.

Mr. MCCAIN. Mr. President, I am pleased to be joining my friend and colleague from Washington, Senator CANTWELL, to introduce the Banking Integrity Act of 2009. My reasons for joining this effort are simple—I want to ensure that we never stick the American taxpayer with another $700 billion tab to bail out the financial industry. If big Wall Street institutions want to take part in risky transactions—fine. But we should not allow them to do so with federally insured deposits.

Paul Volcker, a top economist in the Obama administration and former Federal Reserve Chairman, wants the nation's banks to be prohibited from owning and trading risky securities, the very practice that got the biggest ones into deep trouble in 2008. The administration is saying no, it will not separate commercial banking from investment operations. Mr. Volcker argues that regulation by itself will not work. Sooner or later, the giants, in pursuit of profits, will get into trouble. The administration should accept this and shield commercial banking from Wall Street's wild ways. ''The banks are there to serve the public,'' Mr. Volcker said, ''and that is what they should concentrate on. These other activities create conflicts of interest. They create risks, and if you try to control the risks with supervision, that just creates friction and difficulties'' and ultimately fails.

The bill we are introducing today precludes any member bank of the Federal Reserve System from being affiliated with any entity or organization that is engaged principally in the issue, flotation, underwriting, public sale or distribution of stocks, bonds, debentures or other securities. Essentially, commercial banks may no longer intermingle their business activities with investment banks. It is that simple.

Since the repeal of the Glass Steagall Act in 1999, this country has seen a new culture emerge in the financial industry: one of dangerous greed and excessive risk-taking. Commercial banks traditionally used people's deposits for the constructive purpose of main street loans. They did not engage in high risk ventures. Investment banks, however, managed rich people's money—those who can afford to take bigger risks in order to get a bigger return, and who bore their own losses. When these two worlds collided, the investment bank culture prevailed, cutting off the credit lifeblood of main street firms, demanding greater returns that were achievable only through high leverage and huge risk taking, and leaving taxpayers with the fallout.

When the glass wall dividing banks and securities firms was shattered, common sense and caution went out the door. The new mantra of ''bigger is better'' took over—and the path forward focused on short-term gains rather than long-term planning. Banks became overleveraged in their haste to keep up in the race. The more they lent, the more they made. Aggressive mortgages were underwritten for unqualified individuals who became homeowners saddled with loans they couldn't afford. Banks turned right around and bought portfolios of these shaky loans.

Sub-prime loans made up only five percent of all mortgage lending in 1998, but by the time the financial crisis peaked in late 2008, they were approaching 30 percent. Since January 2008, we have seen 159 state and national banks fail. In my home State of Arizona, five banks have shut their doors, leaving small businesses scrambling to find credit from other banks that may have already been overleveraged.

Banks sold sub-prime mortgages to their affiliates and other securities firms for securitization, while other financial institutions made risky bets on these and other assets for which they had no financial interest. As the market grew bigger, its foundation became shakier. It was like a house of cards waiting to fall, and fall it did.

In October 2008, the financial system was on the brink of collapse when Congress was forced to risk $700 billion of taxpayer dollars to bail out the industry. These financial institutions had become ''too big to fail.'' In fact, the special inspector general of the Troubled Asset Relief Program, TARP, testified before Congress earlier this year that ''total potential Federal Government support could reach $23.7 trillion'' to stabilize and support the financial system. Ironically, some of these ''too big to fail'' institutions have now become even bigger. An editorial from yesterday's New York Times stated:

The truth is that the taxpayers are still very much on the hook for a banking system that is shaping up to be much riskier than the one that led to disaster.

Big bank profits, for instance, still come mostly courtesy of taxpayers. Their trading earnings are financed by more than a trillion dollars' worth of cheap loans from the Federal Reserve, for which some of their most noxious assets are collateral. They benefit from immense federal loan guarantees, but they are not lending much. Lending to business, notably, is very tight.

What profits the banks make come mostly from trading. Many big banks are happy to depend on the lifeline from the Fed and hang onto their toxic assets hoping for a rebound in prices. And the whole system has grown more concentrated. Bank of America was considered too big to fail before the meltdown. Since then, it has acquired Merrill Lynch. Wells Fargo took over Wachovia. JPMorgan Chase gobbled up Bear Stearns.

If the goal is to reduce the number of huge banks that taxpayers must rescue at any cost, the nation is moving in the wrong direction. The growth of the biggest banks ensures that the next bailout will have to be even bigger. These banks will be more likely to take on excessive risk because they have the implicit assurance of rescue.

Excess was a common theme for banks/financial institutions in the mid-2000s—excessive risk, excessive bonuses. Times were good at Merrill Lynch in 2006 when the firm's risky mortgage business was booming. The firm made record earnings of $7.5 billion that year and paid out bonuses of $5 billion to $6 billion. Fast forward to late 2008 when Merrill's gambling left it in deep financial despair with losses exceeding $27 billion. Yet we witnessed the firm pay out another $3.6 billion in bonuses just before it was acquired by Bank of America.

Merrill Lynch wasn't alone in excess and greed. Citigroup posted a net loss of nearly $28 billion in 2008, yet paid out $5.3 billion in bonuses. Although Goldman Sachs earned only $2.3 billion, it paid out $4.8 billion in bonuses. Morgan Stanley earned $1.7 billion, and paid out nearly $4.5 billion in bonuses. JPMorgan Chase earned $5.6 billion and paid $8.7 billion in bonuses. If a company doesn't make money, how can it pay these bonuses? In this case, each of these firms was a recipient of billions in taxpayer-funded TARP money.

The Federal Government has set a dangerous precedent here. We sent the wrong message to the financial industry: you engage in bad, risky business practices, and when you get into trouble, the government will be there to save your hide. Many would call it a moral hazard. I call it a taxpayer-funded subsidy for risky behavior.

The consolidation of the banking world was also riddled with conflicts of interest, despite the purported firewalls that were put into place. If an investment bank had underwritten shares for a company that was now in financial trouble, the investment bank's commercial arm would feel pressure to lend the company money, despite the lack of merits to do so. The Banking Integrity Act of 2009 would eliminate some of these conflicts.

Today, it is time to put a stop to the taxpayer-financed excesses of Wall Street. No single financial institution should be so big that its failure would bring ruin to our economy and destroy millions of American jobs. This country would be better served if we limit the activities of these financial institutions. Banks should accept consumer deposits and invest conservatively, while investment banks engage in underwriting and sales of securities.

I urge my colleagues to support this bill.

By Mr. FEINGOLD:

S. 2890. A bill to amend the Buy American Act to increase the requirement for American-made content, to tighten the waiver provisions, and for other purposes; to the Committee on Homeland Security and Governmental Affairs.

Mr. FEINGOLD. Mr. President, today I am introducing legislation to help American workers and companies.

The bill that I am introducing, the Buy American Improvement Act, focuses on the Federal Government's responsibility to support domestic manufacturers and workers and on the role of Federal procurement policy in achieving this goal. The reintroduction of this bill, which I first introduced in 2003, is part of my ongoing efforts to support American workers and manufacturing.

The Buy American Act of 1933 is the primary statute that governs Federal procurement. The name of this law accurately describes its purpose: to ensure that the Federal Government supports domestic companies and domestic workers by buying American-made goods. Regrettably, this law contains a number of loopholes that make it too easy for government agencies to buy foreign-made goods.

My bill, the Buy American Improvement Act, would strengthen the existing law by tightening its waiver provisions. Currently, the heads of Federal departments and agencies are given broad discretion to waive the act and buy foreign goods with little or no accountability. We should ensure that the Federal Government makes every effort to give Federal contracts to companies that will perform the work domestically. We should also ensure that certain types of industries do not leave the U.S. completely, thus making the Federal Government dependent on foreign sources for goods, such as plane or ship parts, that our military may need to acquire on short notice.

With unemployed workers in the U.S. facing a double-digit unemployment rate, the highest rate since 1983, it is critical Congress back efforts to support American workers. Many unemployed American workers are currently facing persistently long periods of unemployment; data from the Department of Labor showed that in October of this year, over 35 percent of unemployed workers had been without jobs for at least 27 weeks. Since December of 2007, the number of unemployed workers in the U.S. has grown by over 8 million, with manufacturing and construction workers being particularly hard-hit. We need to do all we can to promote fiscally responsible Federal policies that support the creation of American jobs to help get the unemployed and Funderemployed back to work. A strong Buy American Act should be part of the Federal effort to create and retain American jobs.

During another period of economic upheaval in the 1930s, Congress passed a series of laws designed to promote job growth in the U.S., including the Buy American Act of 1933, 41 U.S.C. §10a–10d. The Buy American Act requires the Federal Government to support domestic manufacturers and workers by purchasing American-made goods. Over the years, other domestic sourcing legislation has been passed to help support American industry, including the Buy America Act, 23 U.S.C. §313, which applies to Federal transportation funding. In addition, Congress included domestic sourcing requirements in the American Recovery and Reinvestment Act, P.L. 111–5, earlier this year because it recognized the importance of supporting American workers and American industry. My legislation would help American industry by making it more difficult to waive the Buy American Act and help ensure the Federal Government does all it can to support American workers.

I have a long record of supporting efforts to help taxpayers get the most bang for their buck and opposing wasteful Federal spending. I don't think anyone can argue that supporting American jobs is ''wasteful.'' We owe it to American manufacturers and their employees to make sure they get a fair shake. I would not support awarding a contract to an American company that is price-gouging, but we should make every effort to ensure that domestic sources for goods needed by the Federal Government do not dry up because American companies have been slightly underbid by foreign competitors.

The gaping loopholes in the Buy American Act and the trade agreements and defense procurement agreements that contain additional waivers of domestic source restrictions have combined to weaken our domestic

manufacturing base by allowing—and sometimes actually encouraging—the Federal Government to buy foreign-made goods. Congress can and should do more to support American companies and American workers. We must strengthen the Buy American Act and we must stop entering into bad trade agreements that send our jobs overseas and undermine our own domestic preference laws.

By strengthening Federal procurement policy, we can help to bolster our domestic manufacturers during these difficult times. As I have repeatedly noted, Congress cannot simply stand on the sidelines while tens of thousands of American manufacturing jobs have been and continue to be shipped overseas. While there may be no single solution to this problem one way in which Congress should act is by strengthening the Buy American Act.

By Mr. REID (for himself, Mr. ENSIGN, Mrs. FEINSTEIN, and Mrs. BOXER):

S. 2891. A bill to further allocate and expand the avaiability of hydroelectric power generated at Hoover Dam, and for other purposes; to the Committee on Energy and Natural Resources.

Mr. REID. Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the text of the bill was ordered to be printed in the RECORD, as follows:

S. 2891

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Hoover Power Allocation Act of 2009''.

SEC. 2. ALLOCATION OF CONTRACTS FOR POWER.

(a) SCHEDULE A POWER.—Section 105(a)(1)(A) of the Hoover Power Plant Act of 1984 (43 U.S.C. 619a(a)(1)(A)) is amended—

(1) by striking ''renewal'';

(2) by striking ''June 1, 1987'' and inserting ''October 1, 2017''; and

(3) by striking Schedule A and inserting the following:

''SCHEDULE A

Long term Schedule A contingent capacity and associated firm energy for offers of contracts to Boulder Canyon project contractors

Contractor	Contingent capacity (kW)	Firm Energy (thousands of kWh)		
		Summer	Winter	Total
Metropolitan Water District of Southern California	249,948	859,163	368,212	1,227,375
City of Los Angeles	495,732	464,108	199,175	663,283
Southern California Edison Company	280,245	166,712	71,448	238,160
City of Glendale	18,178	45,028	19,297	64,325
City of Pasadena	11,108	38,622	16,553	55,175
City of Burbank	5,176	14,070	6,030	20,100
Arizona Power Authority	190,869	429,582	184,107	613,689
Colorado River Commission of Nevada	190,869	429,582	184,107	613,689
United States, for Boulder City	20,198	53,200	22,800	76,000
Totals	1,462,323	2,500,067	1,071,729	3,571,796''.

(b) SCHEDULE B POWER.—Section 105(a)(1)(B) of the Hoover Power Plant Act of 1984 (43 U.S.C. 619a(a)(1)(B)) is amended to read as follows:

''(B) To each existing contractor for power generated at Hoover Dam, a contract, for delivery commencing October 1, 2017, of the amount of contingent capacity and firm energy specified for that contractor in the following table:

''SCHEDULE B

Long term Schedule B contingent capacity and associated firm energy for offers of contracts to Boulder Canyon project contractors

Contractor	Contingent capacity (kW)	Firm Energy (thousands of kWh)		
		Summer	Winter	Total
City of Glendale	2,020	2,749	1,194	3,943
City of Pasadena	9,089	2,399	1,041	3,440
City of Burbank	15,149	3,604	1,566	5,170
City of Anaheim	40,396	34,442	14,958	49,400
City of Azusa	4,039	3,312	1,438	4,750
City of Banning	2,020	1,324	576	1,900
City of Colton	3,030	2,650	1,150	3,800
City of Riverside	30,296	25,831	11,219	37,050
City of Vernon	22,218	18,546	8,054	26,600
Arizona	189,860	140,600	60,800	201,400
Nevada	189,860	273,600	117,800	391,400
Totals	507,977	509,057	219,796	728,853''.

(c) SCHEDULE C POWER.—Section 105(a)(1)(C) of the Hoover Power Plant Act of 1984 (43 U.S.C. 619a(a)(1)(C)) is amended—

(1) by striking ''June 1, 1987'' and inserting ''October 1, 2017''; and

(2) by striking Schedule C and inserting the following:

''SCHEDULE C

Excess Energy

Priority of entitlement to excess energy	State
First: Meeting Arizona's first priority right to delivery of excess energy which is equal in each year of operation to 200 million kilowatthours: Provided, That in the event excess energy in the amount of 200 million kilowatthours is not generated during any year of operation, Arizona shall accumulate a first right to delivery of excess energy subsequently generated in an amount not to exceed 600 million kilowatthours, inclusive of the current year's 200 million kilowatthours. Said first right of delivery shall accrue at a rate of 200 million kilowatthours per year for each year excess energy in an amount of 200 million kilowatthours is not generated, less amounts of excess energy delivered.	Arizona

''SCHEDULE C—Continued

Excess Energy

Priority of entitlement to excess energy	State
Second: Meeting Hoover Dam contractual obligations under Schedule A of subsection (a)(1)(A), under Schedule B of subsection (a)(1)(B), and under Schedule D of subsection (a)(2), not exceeding 26 million kilowatthours in each year of operation.	Arizona, Nevada, and California
Third: Meeting the energy requirements of the three States, such available excess energy to be divided equally among the States.	Arizona, Nevada, and California''.

(d) SCHEDULE D POWER.—Section 105(a) of the Hoover Power Plant Act of 1984 (43 U.S.C. 619a(a)) is amended—

(1) by redesignating paragraphs (2), (3), and (4) as paragraphs (3), (4), and (5), respectively; and

(2) by inserting after paragraph (1) the following:

''(2)(A) The Secretary of Energy is authorized to and shall create from the apportioned allocation of contingent capacity and firm energy adjusted from the amounts authorized in this Act in 1984 to the amounts shown in Schedule A and Schedule B, as modified by the Hoover Power Allocation Act of 2009, a resource pool equal to 5 percent of the full rated capacity of 2,074,000 kilowatts, and associated firm energy, as shown in Schedule D (referred to in this section as 'Schedule D contingent capacity and firm energy'):

''SCHEDULE D

Long term Schedule D resource pool of contingent capacity and associated firm energy for new allottees

State	Contingent capacity (kW)	Firm Energy (thousands of kWh)		
		Summer	Winter	Total
New Entities Allocated by the Secretary of Energy	69,170	105,637	45,376	151,013
New Entities Allocated by State				
Arizona	11,510	17,580	7,533	25,113
California	11,510	17,580	7,533	25,113
Nevada	11,510	17,580	7,533	25,113
Totals	103,700	158,377	67,975	226,352

''(B) The Secretary of Energy shall offer Schedule D contingency capacity and firm energy to entities not receiving contingent capacity and firm energy under subparagraphs (A) and (B) of paragraph (1) (referred to in this section as 'new allottees') for delivery commencing October 1, 2017 pursuant to this subsection. In this subsection, the term 'the marketing area for the Boulder City Area Projects' shall have the same meaning as in Appendix A of the General Consolidated Power Marketing Criteria or Regulations for Boulder City Area Projects published in the Federal Register on December 28, 1984 (49 Fed. Reg. 50582 et seq.) (referred to in this section as the 'Criteria').

''(C)(i) Within 18 months of the date of enactment of the Hoover Power Allocation Act of 2009, the Secretary of Energy shall allocate through the Western Area Power Administration (referred to in this section as 'Western'), for delivery commencing October 1, 2017, for use in the marketing area for the Boulder City Area Projects 66.7 percent of the Schedule D contingent capacity and firm energy to new allottees that are located within the marketing area for the Boulder City Area Projects and that are—

''(I) eligible to enter into contracts under section 5 of the Boulder Canyon Project Act (43 U.S.C. 617d); or

''(II) federally recognized Indian tribes.

''(ii) In the case of Arizona and Nevada, Schedule D contingent capacity and firm energy for new allottees shall be offered through the Arizona Power Authority and the Colorado River Commission of Nevada, respectively.

''(iii) In performing its allocation of Schedule D power provided for in this subparagraph, Western shall apply criteria developed in consultation with the States of Arizona, Nevada, and California.

''(D) Within 1 year of the date of enactment of the Hoover Power Allocation Act of 2009, the Secretary of Energy also shall allocate, for delivery commencing October 1, 2017, for use in the marketing area for the Boulder City Area Projects 11.1 percent of the Schedule D contingent capacity and firm energy to each of—

''(i) the Arizona Power Authority for allocation to new allottees in the State of Arizona;

''(ii) the Colorado River Commission of Nevada for allocation to new allottees in the State of Nevada; and

''(iii) Western for allocation to new allottees within the State of California.

''(E) Each contract offered pursuant to this subsection shall include a provision requiring the new allottee to pay a proportionate share of its State's respective contribution (determined in accordance with each State's applicable funding agreement) to the cost of the Lower Colorado River Multi-Species Conservation Program (as defined in section 9401 of the Omnibus Public Land Management Act of 2009 (Public Law 111–11; 123 Stat. 1327)), and to execute the Boulder Canyon Project Implementation Agreement Contract No. 95–PAO–10616 (referred to in this section as the 'Implementation Agreement').

''(F) Any of the 66.7 percent of Schedule D contingent capacity and firm energy that is to be allocated by Western that is not allocated and placed under contract by October 1, 2017, shall be returned to those contractors shown in Schedule A and Schedule B in the same proportion as those contractors' allocations of Schedule A and Schedule B contingent capacity and firm energy. Any of the 33.3 percent of Schedule D contingent capacity and firm energy that is to be distributed within the States of Arizona, Nevada, and California that is not allocated and placed under contract by October 1, 2017, shall be returned to the Schedule A and Schedule B contractors within the State in which the Schedule D contingent capacity and firm energy were to be distributed, in the same proportion as those contractors' allocations of Schedule A and Schedule B contingent capacity and firm energy.''.

(e) TOTAL OBLIGATIONS.—Paragraph (3) of section 105(a) of the Hoover Power Plant Act of 1984 (43 U.S.C. 619a(a)) (as redesignated as subsection (d)(1)) is amended—

(1) in the first sentence, by striking ''schedule A of subsection (a)(1)(A) of this section and schedule B of subsection (a)(1)(B) of this section'' and inserting ''pursuant to paragraphs (1)(A), (1)(B), and (2)''; and

(2) in the second sentence—

(A) by striking ''any'' and inserting ''each'';

(B) by striking ''schedule C'' and inserting ''Schedule C''; and

(C) by striking ''schedules A and B'' and inserting ''Schedules A, B, and D''.

(f) POWER MARKETING CRITERIA.—Paragraph (4) of section 105(a) of the Hoover Power Plant Act of 1984 (43 U.S.C. 619a(a)) (as redesignated as subsection (d)(1)) is amended to read as follows:

''(4) Subdivision E of the Criteria shall be deemed to have been modified to conform to this section, as modified by the Hoover Power Allocation Act of 2009. The Secretary of Energy shall cause to be included in the Federal Register a notice conforming the text of the regulations to such modifications.''.

(g) CONTRACT TERMS.—Paragraph (5) of section 105(a) of the Hoover Power Plant Act of 1984 (43 U.S.C. 619a(a)) (as redesignated as subsection (d)(1)) is amended—

(1) by striking subparagraph (A) and inserting the following:

''(A) in accordance with section 5(a) of the Boulder Canyon Project Act (43 U.S.C. 617d(a)), expire September 30, 2067;'';

(2) in the proviso of subparagraph (B)—

(A) by striking ''shall use'' and inserting ''shall allocate''; and

(B) by striking ''and'' after the semicolon at the end;

(3) in subparagraph (C), by striking the period at the end and inserting a semicolon; and

(4) by adding at the end the following:

''(D) authorize and require Western to collect from new allottees a pro rata share of Hoover Dam repayable advances paid for by contractors prior to October 1, 2017, and remit such amounts to the contractors that paid such advances in proportion to the amounts paid by such contractors as specified in section 6.4 of the Implementation Agreement;

''(E) permit transactions with an independent system operator; and

''(F) contain the same material terms included in section 5.6 of those long term contracts for purchases from the Hoover Power Plant that were made in accordance with this Act and are in existence on the date of enactment of the Hoover Power Allocation Act of 2009.''.

(h) EXISTING RIGHTS.—Section 105(b) of the Hoover Power Plant Act of 1984 (43 U.S.C. 619a(b)) is amended by striking ''2017'' and inserting ''2067''.

(i) OFFERS.—Section 105(c) of the Hoover Power Plant Act of 1984 (43 U.S.C. 619a(c)) is amended to read as follows:

''(c) OFFER OF CONTRACT TO OTHER ENTITIES.—If any existing contractor fails to accept an offered contract, the Secretary of Energy shall offer the contingent capacity and firm energy thus available first to other entities in the same State listed in Schedule A and Schedule B, second to other entities listed in Schedule A and Schedule B, third to other entities in the same State which receive contingent capacity and firm energy under subsection (a)(2) of this section, and last to other entities which receive contingent capacity and firm energy under subsection (a)(2) of this section.''.

(j) AVAILABILITY OF WATER.—Section 105(d) of the Hoover Power Plant Act of 1984 (43 U.S.C. 619a(d) is amended to read as follows:

''(d) WATER AVAILABILITY.—Except with respect to energy purchased at the request of an allottee pursuant to subsection (a)(3), the obligation of the Secretary of Energy to deliver contingent capacity and firm energy pursuant to contracts entered into pursuant to this section shall be subject to availability of the water needed to produce such contingent capacity and firm energy. In the event that water is not available to produce the contingent capacity and firm energy set forth in Schedule A, Schedule B, and Schedule D, the Secretary of Energy shall adjust the contingent capacity and firm energy offered under those Schedules in the same proportion as those contractors' allocations of Schedule A, Schedule B, and Schedule D contingent capacity and firm energy bears to the full rated contingent capacity and firm energy obligations.''.

(k) CONFORMING AMENDMENTS.—Section 105 of the Hoover Power Plant Act of 1984 (43 U.S.C. 619a) is amended—

(1) by striking subsections (e) and (f); and

(2) by redesignating subsections (g), (h), and (i) as subsections (e), (f), and (g), respectively.

(l) CONTINUED CONGRESSIONAL OVERSIGHT.—Subsection (e) of section 105 of the Hoover Power Plant Act of 1984 (43 U.S.C. 619a)) (as redesignated by subsection (k)(2)) is amended—

(1) in the first sentence, by striking ''the renewal of''; and

(2) in the second sentence, by striking ''June 1, 1987, and ending September 30, 2017'' and inserting ''October 1, 2017, and ending September 30, 2067''.

(m) COURT CHALLENGES.—Subsection (f)(1) of section 105 of the Hoover Power Plant Act of 1984 (43 U.S.C. 619a) (as redesignated by subsection (k)(2)) is amended in the first sentence by striking ''this Act'' and inserting ''the Hoover Power Allocation Act of 2009''.

(n) REAFFIRMATION OF CONGRESSIONAL DECLARATION OF PURPOSE.—Subsection (g) of section 105 of the Hoover Power Plant Act of 1984 (43 U.S.C. 619a) (as redesignated by subsection (k)(2)) is amended—

(1) by striking ''subsections (c), (g), and (h) of this section'' and inserting ''this Act''; and

(2) by striking ''June 1, 1987, and ending September 30, 2017'' and inserting ''October 1, 2017, and ending September 30, 2067''.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 376—HONORING THE 60TH ANNIVERSARY OF THE ESTABLISHMENT OF DIPLOMATIC RELATIONS BETWEEN THE UNITED STATES AND THE HASHEMITE KINGDOM OF JORDAN, THE 10TH ANNIVERSARY OF THE ACCESSION TO THE THRONE OF HIS MAJESTY KING ABDULLAH II IBN AL HUSSEIN, AND FOR OTHER PURPOSES

Mr. INOUYE (for himself, Mr. GREGG, Mr. LIEBERMAN, and Mr. DURBIN) submitted the following resolution; which was considered and agreed to:

S. RES. 376

Whereas the Hashemite Kingdom of Jordan achieved independence on May 25, 1946;

Whereas the United States recognized Jordan as an independent state in a White House announcement on January 31, 1949;

Whereas diplomatic relations and the American Legation in Jordan were established on February 18, 1949, when United States diplomat Wells Stabler presented his credentials as Chargé d'Affaires in Amman;

Whereas, for 60 years, the United States and Jordan have enjoyed a close relationship and have worked together to advance issues ranging from the promotion of Middle East peace to advancing the socio-economic development of the people of Jordan, as well as the threat to both posed by al Qaeda and violent extremism;

Whereas, from 1952 to 1999, King Hussein charted a moderate path for his country;

Whereas, for decades, the United States has been Jordan's strongest international partner;

Whereas, throughout his reign, King Hussein looked for opportunities to realize his dream of a more peaceful Middle East by working to solve intra-Arab disputes and engaging successive Prime Ministers of Israel in the search for peace;

Whereas King Hussein and Prime Minister of Israel Yitzhak Rabin signed the historic Jordan-Israel peace treaty in 1994, ending nearly 50 years of war between the neighboring countries;

Whereas the United States lost a close friend and a crucial partner when King Hussein passed away in 1999;

Whereas King Hussein was succeeded by his son, King Abdullah II, who has continued his father's work to improve the lives of the people of Jordan while also seeking to bring peace to the region;

Whereas, in the aftermath of the September 11, 2001, terrorist attacks, the Government of Jordan has been an instrumental partner in the fight against al Qaeda, has provided crucial assistance in Iraq, and has shouldered a heavy burden in providing refuge to a significant portion of the Iraqi refugee population;

Whereas, through his 2004 Amman Message, King Abdullah II has been a leading Arab voice in trying to reaffirm the true path of Islam;

Whereas, in November 2005, al Qaeda terrorists struck three hotels in Amman, Jordan, thereby uniting the people of Jordan and the United States in grief over the lives lost at this act of terrorism; and

Whereas King Abdullah II begins his second decade on the Hashemite throne by redoubling his efforts for peace in the region as the Jordan-United States partnership enters its seventh decade: Now, therefore, be it

Resolved, That the Senate—

(1) commemorates the 60th anniversary of the close relationship between the United States and the Hashemite Kingdom of Jordan;

(2) expresses its profound admiration and gratitude for the friendship of the people of Jordan;

(3) congratulates His Majesty King Abdullah II on 10 years of enlightened and progressive rule; and

(4) shares the hope of His Majesty King Abdullah II and the people of Jordan for a more peaceful Middle East.

SENATE CONCURRENT RESOLUTION 48—RECOGNIZING THE LEADERSHIP AND HISTORICAL CONTRIBUTIONS OF DR. HECTOR GARCIA TO THE HISPANIC COMMUNITY AND HIS REMARKABLE EFFORTS TO COMBAT RACIAL AND ETHNIC DISCRIMINATION IN THE UNITED STATES OF AMERICA

Mr. MENENDEZ submitted the following concurrent resolution; which was referred to the Committee on the Judiciary:

S. CON. RES. 48

Whereas Dr. Hector Garcia changed the lives of Americans from all walks of life;

Whereas Dr. Hector Garcia was born in Mexico on January 17, 1914, and immigrated to Mercedes, Texas, in 1918;

Whereas Dr. Hector Garcia is an honored alumnus of the School of Medicine at the University of Texas Medical Branch, Class of 1940;

Whereas Dr. Hector Garcia fought in World War II, specifically in North Africa and Italy, attained the rank of Major, and was awarded the Bronze Star with six battle stars;

Whereas once the Army discovered he was a physician, Dr. Hector Garcia was asked to practice his profession by treating his fellow soldiers;

Whereas Dr. Hector Garcia moved to Corpus Christi, Texas, after the war, and opened a medical practice; rarely charged his indigent patients, and was recognized as a passionate and dedicated physician;

Whereas he first became known in south Texas for his public health messages on the radio with topics ranging from infant diarrhea to tuberculosis;

Whereas Dr. Hector Garcia continued his public service and advocacy and became founder of the American G.I. Forum, a Mexican-American veterans association, which initiated countless efforts on behalf of Americans to advance opportunities in health care, veterans' benefits, and civil rights equality;

Whereas his civil rights movement would then grow to also combat discrimination in housing, jobs, education, and voting rights;

Whereas President Kennedy appointed Dr. Hector Garcia a member of the American Treaty Delegation for the Mutual Defense Agreement between the United States and the Federation of the West Indies;

Whereas in 1967, President Lyndon Johnson appointed Dr. Hector Garcia as alternate ambassador to the United Nations where he gave the first speech by an American before the United Nations in a language other than English;

Whereas Dr. Hector Garcia was named member of the Texas Advisory Committee to the United States Commission on Civil Rights;

Whereas President Reagan presented Dr. Hector Garcia the Nation's highest civilian

award, the Medal of Freedom, in 1984 for meritorious service to his country, the first Mexican American to receive this recognition; and

Whereas Pope John Paul II recognized him with the Pontifical Equestrian Order of Pope Gregory the Great: Now, therefore, be it

Resolved by the Senate (the House of Representatives concurring), That Congress—

(1) encourages—

(A) teachers of primary schools and secondary schools to launch educational campaigns to inform students about the lifetime of accomplishments by Dr. Hector Garcia; and

(B) all people of the United States to educate themselves about the legacy of Dr. Hector Garcia; and

(2) recognizes the leadership and historical contributions of Dr. Hector Garcia to the Hispanic community and his remarkable efforts to combat racial and ethnic discrimination in the United States of America.

AMENDMENTS SUBMITTED AND PROPOSED

SA 3242. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees , and for other purposes; which was ordered to lie on the table.

SA 3243. Mr. GRASSLEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3244. Mr. GRASSLEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3245. Mr. GRASSLEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3246. Mr. CASEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3247. Mr. GRASSLEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3248. Mr. REID proposed an amendment to the bill H.R. 3326, making appropriations for the Department of Defense for the fiscal year ending September 30, 2010, and for other purposes.

SA 3249. Mr. REID proposed an amendment to the bill H.R. 3326, supra.

SA 3250. Mr. REID proposed an amendment to amendment SA 3249 proposed by Mr. REID to the bill H.R. 3326, supra.

SA 3251. Mr. REID proposed an amendment to amendment SA 3250 proposed by Mr. REID to the amendment SA 3249 proposed by Mr. REID to the bill H.R. 3326, supra.

SA 3252. Mr. REID proposed an amendment to amendment SA 3248 proposed by Mr. REID to the bill H.R. 3326, supra.

SA 3253. Ms. MURKOWSKI submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table.

SA 3254. Ms. MURKOWSKI submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3255. Ms. MURKOWSKI submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3256. Mr. BENNET submitted an amendment intended to be proposed by him to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3257. Ms. MURKOWSKI submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3258. Mrs. SHAHEEN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

TEXT OF AMENDMENTS

SA 3242. Mr. CRAPO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1053, between lines 2 and 3, insert the following:

SEC. 3403A. IMPROVEMENTS TO THE INDEPENDENT MEDICARE ADVISORY BOARD.

Section 1899A of the Social Security Act, as added by section 3403, is amended—

(1) in subsection (c)—

(A) in paragraph (1)—

(i) by redesignating subparagraph (B) as subparagraph (C); and

(ii) by inserting after subparagraph (A) the following new subparagraph:

''(B) PROMULGATION OF REGULATIONS TO PROVIDE FOUNDATION FOR BOARD PROPOSALS.—

''(i) IN GENERAL.—Before developing any proposal under this section, the Board, after consultation with the Secretary, shall promulgate regulations through which the Board interprets the provisions of this section that concern the duties of the Board in order to provide a substantive and procedural foundation for carrying out such duties. Such regulations shall be promulgated in accordance with the procedures under section 553 of title 5, United States Code, that relate to substantive rules.

''(ii) RULE OF CONSTRUCTION.—Clause (i) may not be construed as requiring that proposals under this section be promulgated in accordance with the rulemaking procedures referred to in clause (i).'';

(B) in paragraph (2), by adding at the end the following new subparagraphs:

''(G) CONSULTATION WITH INDEPENDENT ADVISORY COMMITTEE.—

''(i) IN GENERAL.—Not later than 60 days after the date of the enactment of the Patient Protection and Affordable Care Act, the Secretary shall establish an advisory committee to review, in accordance with procedures established in the Federal Advisory Committee Act, each proposal to be submitted to Congress under this section.

''(ii) COMPOSITION.—The advisory committee under clause (i) (referred to in this subparagraph as the 'Independent Committee') shall be composed of not more than 15 members who are medical and scientific experts appointed from among individuals who are not officers or employees of the Federal Government.

''(iii) REVIEW AND REPORT.—The Board shall submit a draft copy of each proposal to be submitted to the President under this section to the Independent Committee for its review. The Board shall submit such draft copy by not later than September 1 of the year preceding the year for which the proposal is to be submitted. Not later than November 1 of such year, the Independent Committee shall submit a report to Congress and the Board on the results of such review, including matters reviewed pursuant to the succeeding provisions of this subparagraph.

''(iv) CLINICAL APPROPRIATENESS OF PAYMENT RESTRICTIONS AND COVERAGE RESTRICTIONS.—The review of the Independent Committee of a recommendation in a proposal under this section shall, with respect to any changes in items or services under this title, include evaluating the differences in treatment guidelines and variables of treatment costs for items and services under this title that are subject to a reduction in payment or restriction in coverage pursuant to the recommendation. The purpose of such evaluation shall be to ensure that the recommendation applies only to those items and services for which such comparisons may be made in a clinically appropriate manner.

''(v) SUBSTANTIAL EVIDENCE REGARDING CERTAIN RECOMMENDATIONS.—With respect to a recommendation in a proposal of the Board that reduces payment or restricts coverage for items and services under this title, the Independent Committee shall determine whether the recommendation is supported by substantial evidence.

''(vi) SPECIAL POPULATIONS; HEALTH DISPARITIES.—In reviewing a recommendation in a proposal under this section, the Independent Committee shall evaluate the effect on special populations and whether the recommendation is consistent with Federal policies to reduce health disparities.

''(vii) PUBLIC MEETING TO PRESENT AND DISCUSS FINDINGS.—Before issuing a report under clause (iii), the Independent Committee shall hold a public meeting at which it presents the findings of its review under such clause and seeks comments from individuals attending the meeting.

''(H) PUBLICATION OF INITIAL PROPOSAL IN FEDERAL REGISTER.—

''(i) IN GENERAL.—Not later than October 1 preceding the proposal year involved, the Board shall publish in the Federal Register an initial proposal of the Board under this section and shall seek comments from the public on the proposal. The final proposal shall be published in the Federal Register on the same date as the date on which such proposal is submitted to the President under paragraph (3)(A) (or under paragraph (5), as the case may be).

''(ii) LIMITATION ON JUDICIAL REVIEW.—The publication under clause (i) of a final proposal of the Board does not constitute final agency action for purposes of section 704 of title 5, United States Code.''; and

(C) in paragraph (3)(B), by striking clause (ii) and inserting the following new clause:

''(ii) taking into account comments received from the public under paragraph (2)(H)(i), an explanation of each recommendation contained in the proposal and the reasons for including such recommendation, and a statement of whether and to what extent the Board considered it feasible—

''(I) to protect and improve Medicare beneficiaries' access to necessary and evidence-based items and services, including in rural and frontier areas; and

''(II) to otherwise comply with the requirements of paragraph (2)(B); and''; and

(2) in subsection (e), by striking paragraph (5) and inserting the following new paragraph:

''(5) LIMITATION ON REVIEW.—

''(A) IN GENERAL.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the implementation by the Secretary under this subsection of the recommendations contained in a proposal, except as provided in subparagraph (B).

''(B) JUDICIAL REVIEW OF SCOPE OF AGENCY AUTHORITY; COMPLIANCE WITH PROCEDURAL SAFEGUARDS.—

''(i) IN GENERAL.—An aggrieved beneficiary or other party may, in accordance with the procedures that apply under section 1869(f)(3), seek review by a court of competent jurisdiction of the implementation by the Secretary of any recommendation in a proposal of the Board if the moving party alleges that the only issue of law is the constitutionality of a recommendation, or one or more issues described in clause (ii). For purposes of this subparagraph, a regulation, determination, or ruling by the Secretary under such a recommendation is final agency action within the meaning of section 704 of title 5, United States Code.

''(ii) RELEVANT ISSUES; PROCEDURAL SAFEGUARDS.—For purposes of clause (i), the court shall hold unlawful and set aside a regulation, determination, or ruling by the Secretary under a recommendation in a proposal of the Board if the court finds that—

''(I) the regulation, determination, or ruling exceeds the scope of the recommendation;

''(II) the Board failed to promulgate regulations in accordance with subsection (c)(1)(B) (relating to a substantive and procedural foundation for carrying out the duties of the Board);

''(III) the Board failed to comply with subsection (c)(2)(A)(ii) (relating to prohibitions against rationing health care; increasing beneficiary cost-sharing, such as deductibles, coinsurance, and copayments; or otherwise restricting benefits or modifying eligibility criteria);

''(IV) the Board failed to comply with subparagraph (D), (E), (G), or (H) of subsection (c)(2) (relating to review by the Medicare Payment Advisory Board, review by the Secretary, review by an independent advisory panel of experts, and publishing initial and final proposals of the Board in the Federal Register, respectively); or

''(V) the Board failed to comply with subsection (c)(3)(B)(ii) (relating to providing explanations of recommendations, providing statements of whether certain duties are feasible, and taking into account public comments).

''(iii) SUBSTANTIAL EVIDENCE REGARDING CERTAIN RECOMMENDATIONS.—With respect to a recommendation in a proposal of the Board under this section that reduces payment or restricts coverage for items and services under this title:

''(I) The review by a court under clause (i) of the implementation by the Secretary of the recommendation shall include a review of the basis of the recommendation.

''(II) The court shall hold unlawful and set aside the recommendation, and any regulation, determination, or ruling by the Secretary under the recommendation, if the court finds that the recommendation is unsupported by substantial evidence within the meaning of section 706 of title 5, United States Code.''.

SA 3243. Mr. GRASSLEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1790, between lines 9 and 10, insert the following:

SEC. 6508. REQUIREMENT FOR ALL MEDICAID AND CHIP APPLICANTS TO PRESENT AN IDENTIFICATION DOCUMENT.

(a) IN GENERAL.—Section 1902 of the Social Security Act (42 U.S.C. 1396a), as amended by section 211(a)(1)(A)(i) of Public Law 111–3 and section 2303(a)(2) of this Act, is amended—

(1) in subsection (a)(46), —

(A) in subparagraph (A), by striking ''and'' after the semicolon;

(B) in subparagraph (B), by adding ''and'' after the semicolon; and

(C) by adding at the end the following:

''(C) provide that each applicant for medical assistance (or the parent or guardian of an applicant who has not attained age 18), regardless of whether the applicant is described in paragraph (2) of section 1903(x), shall present an identification document described in subsection (jj) when applying for medical assistance (and shall be provided with at least the reasonable opportunity to present such identification as is provided under clauses (i) and (ii) of section 1137(d)(4)(A) to an individual for the submittal to the State of evidence indicating a satisfactory immigration status;''; and

(2) by adding at the end the following:

''(jj) For purposes of subsection (a)(46)(C), a document described in this subsection is—

''(1) in the case of an individual who is a national of the United States—

''(A) a United States passport, or passport card issued pursuant to the Secretary of State's authority under the first section of the Act of July 3, 1926 (44 Stat. 887, Chapter 772; 22 U.S.C. 211a); or

''(B) a driver's license or identity card issued by a State, the Commonwealth of the Northern Mariana Islands, or an outlying possession of the United States that—

''(i) contains a photograph of the individual and other identifying information, including the individual's name, date of birth, gender, and address; and

''(ii) contains security features to make the license or card resistant to tampering, counterfeiting, and fraudulent use;

''(2) in the case of an alien lawfully admitted for permanent residence in the United States, a permanent resident card, as specified by the Secretary of Homeland Security that meets the requirements of clauses (i) and (ii) of paragraph (1)(B);

''(3) in the case of an alien who is authorized to be employed in the United States, an employment authorization card, as specified by the Secretary of Homeland Security that meets the requirements of clauses (i) and (ii) of paragraph (1)(B); or

''(4) in the case of an individual who is unable to obtain a document described in paragraph (1), (2), or (3), a document designated by the Secretary of Homeland Security that meets the requirements of clauses (i) and (ii) of paragraph (1)(B).''.

(b) APPLICATION TO CHIP.—Section 2105(c)(9)(A) (42 U.S.C. 1397ee(c)(9)(A)) is amended by striking ''section 1902(a)(46)(B)'' and inserting ''subparagraphs (B) and (C) of subsection (a)(46) and subsection (jj) of section 1902''.

SA 3244. Mr. GRASSLEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

Subtitle __—Improved Patient Access and Medical Care

PART I—EPSDT BENEFITS FOR CHILDREN

SEC. __01. EPSDT BENEFITS FOR CHILDREN.

Section 1902(gg) of the Social Security Act, as added by section 2001(b)(2) of this Act, is amended by redesignating paragraph (4) as paragraph (5) and inserting after paragraph (3) the following:

''(4) STATES CERTIFYING ESSENTIAL BENEFITS AND COST-SHARING PROTECTIONS FOR CHILDREN IN FAMILIES WITH INCOME UP TO 300 PERCENT OF THE POVERTY LINE.—The requirements under paragraphs (1) and (2) and section 2105(d)(3)(A) shall not apply to a State with respect to individuals whose income exceeds 133 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved for any fiscal year or portion of a fiscal year that occurs on or after the date on which the State certifies to the Secretary that—

''(A) coverage available through an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act for children who reside in the State, are under 19 years of age, and are in families with income that does not exceed 300 percent of the poverty line (as so defined), is at least the same as the level of benefits and cost-sharing under the State child health plan under title XXI (whether implemented under that title, this title, or both); and

''(B) the State Medicaid agency and qualified health plans offered through such an Exchange have established adequate procedures, with respect to such children, to ensure access to, and the coordinated provision of—

''(i) services described in section 1905(a)(4)(B) (relating to early and periodic screening, diagnostic, and treatment services defined in section 1905(r)) and provided in accordance with the requirements of section 1902(a)(43); and

''(ii) cost-sharing protections consistent with section 2103(e) of the Social Security Act.

A State may comply with the requirements of subparagraph (B) by providing the services and cost-sharing protections required under that subparagraph directly under the State plan under title XIX or title XXI of the Social Security, or under arrangements entered into with qualified health plans offered through such an Exchange. Expenditures by the State to provide such services and cost-sharing protections shall be treated as medical assistance for purposes of section 1903(a) and, notwithstanding section 1905(b), the enhanced FMAP under section 2105(b) shall

apply to such expenditures. In no event shall a State receive a payment under section 1903(a) for any such expenditures made prior to the date on which an Exchange is established by the State and operating under section 1311 of the Patient Protection and Affordable Care Act.''.

PART II—MEDICAL CARE ACCESS PROTECTION

SEC. __11. SHORT TITLE OF PART.

This part may be cited as the ''Medical Care Access Protection Act of 2009'' or the ''MCAP Act''.

SEC. __12. FINDINGS AND PURPOSE.

(a) FINDINGS.—

(1) EFFECT ON HEALTH CARE ACCESS AND COSTS.—Congress finds that our current civil justice system is adversely affecting patient access to health care services, better patient care, and cost-efficient health care, in that the health care liability system is a costly and ineffective mechanism for resolving claims of health care liability and compensating injured patients, and is a deterrent to the sharing of information among health care professionals which impedes efforts to improve patient safety and quality of care.

(2) EFFECT ON INTERSTATE COMMERCE.—Congress finds that the health care and insurance industries are industries affecting interstate commerce and the health care liability litigation systems existing throughout the United States are activities that affect interstate commerce by contributing to the high costs of health care and premiums for health care liability insurance purchased by health care system providers.

(3) EFFECT ON FEDERAL SPENDING.—Congress finds that the health care liability litigation systems existing throughout the United States have a significant effect on the amount, distribution, and use of Federal funds because of—

(A) the large number of individuals who receive health care benefits under programs operated or financed by the Federal Government;

(B) the large number of individuals who benefit because of the exclusion from Federal taxes of the amounts spent to provide them with health insurance benefits; and

(C) the large number of health care providers who provide items or services for which the Federal Government makes payments.

(b) PURPOSE.—It is the purpose of this part to implement reasonable, comprehensive, and effective health care liability reforms designed to—

(1) improve the availability of health care services in cases in which health care liability actions have been shown to be a factor in the decreased availability of services;

(2) reduce the incidence of ''defensive medicine'' and lower the cost of health care liability insurance, all of which contribute to the escalation of health care costs;

(3) ensure that persons with meritorious health care injury claims receive fair and adequate compensation, including reasonable noneconomic damages;

(4) improve the fairness and cost-effectiveness of our current health care liability system to resolve disputes over, and provide compensation for, health care liability by reducing uncertainty in the amount of compensation provided to injured individuals; and

(5) provide an increased sharing of information in the health care system which will reduce unintended injury and improve patient care.

SEC. __13. DEFINITIONS.

In this part:

(1) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term ''alternative dispute resolution system'' or ''ADR'' means a system that provides for the resolution of health care lawsuits in a manner other than through a civil action brought in a State or Federal court.

(2) CLAIMANT.—The term ''claimant'' means any person who brings a health care lawsuit, including a person who asserts or claims a right to legal or equitable contribution, indemnity or subrogation, arising out of a health care liability claim or action, and any person on whose behalf such a claim is asserted or such an action is brought, whether deceased, incompetent, or a minor.

(3) COLLATERAL SOURCE BENEFITS.—The term ''collateral source benefits'' means any amount paid or reasonably likely to be paid in the future to or on behalf of the claimant, or any service, product or other benefit provided or reasonably likely to be provided in the future to or on behalf of the claimant, as a result of the injury or wrongful death, pursuant to—

(A) any State or Federal health, sickness, income-disability, accident, or workers' compensation law;

(B) any health, sickness, income-disability, or accident insurance that provides health benefits or income-disability coverage;

(C) any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental, or income disability benefits; and

(D) any other publicly or privately funded program.

(4) COMPENSATORY DAMAGES.—The term ''compensatory damages'' means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities, damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature. Such term includes economic damages and noneconomic damages, as such terms are defined in this section.

(5) CONTINGENT FEE.—The term ''contingent fee'' includes all compensation to any person or persons which is payable only if a recovery is effected on behalf of one or more claimants.

(6) ECONOMIC DAMAGES.—The term ''economic damages'' means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities.

(7) HEALTH CARE GOODS OR SERVICES.—The term ''health care goods or services'' means any goods or services provided by a health care institution, provider, or by any individual working under the supervision of a health care provider, that relates to the diagnosis, prevention, care, or treatment of any human disease or impairment, or the assessment of the health of human beings.

(8) HEALTH CARE INSTITUTION.—The term ''health care institution'' means any entity licensed under Federal or State law to provide health care services (including but not limited to ambulatory surgical centers, assisted living facilities, emergency medical services providers, hospices, hospitals and hospital systems, nursing homes, or other entities licensed to provide such services).

(9) HEALTH CARE LAWSUIT.—The term ''health care lawsuit'' means any health care liability claim concerning the provision of health care goods or services affecting interstate commerce, or any health care liability action concerning the provision of (or the failure to provide) health care goods or services affecting interstate commerce, brought in a State or Federal court or pursuant to an alternative dispute resolution system, against a health care provider or a health care institution regardless of the theory of liability on which the claim is based, or the number of claimants, plaintiffs, defendants, or other parties, or the number of claims or causes of action, in which the claimant alleges a health care liability claim.

(10) HEALTH CARE LIABILITY ACTION.—The term ''health care liability action'' means a civil action brought in a State or Federal Court or pursuant to an alternative dispute resolution system, against a health care provider or a health care institution regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action, in which the claimant alleges a health care liability claim.

(11) HEALTH CARE LIABILITY CLAIM.—The term ''health care liability claim'' means a demand by any person, whether or not pursuant to ADR, against a health care provider or health care institution, including third-party claims, cross-claims, counter-claims, or contribution claims, which are based upon the provision of, use of, or payment for (or the failure to provide, use, or pay for) health care services, regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action.

(12) HEALTH CARE PROVIDER.—

(A) IN GENERAL.—The term ''health care provider'' means any person (including but not limited to a physician (as defined by section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r)), registered nurse, dentist, podiatrist, pharmacist, chiropractor, or optometrist) required by State or Federal law to be licensed, registered, or certified to provide health care services, and being either so licensed, registered, or certified, or exempted from such requirement by other statute or regulation.

(B) TREATMENT OF CERTAIN PROFESSIONAL ASSOCIATIONS.—For purposes of this part, a professional association that is organized under State law by an individual physician or group of physicians, a partnership or limited liability partnership formed by a group of physicians, a nonprofit health corporation certified under State law, or a company formed by a group of physicians under State law shall be treated as a health care provider under subparagraph (A).

(13) MALICIOUS INTENT TO INJURE.—The term ''malicious intent to injure'' means intentionally causing or attempting to cause physical injury other than providing health care goods or services.

(14) NONECONOMIC DAMAGES.—The term ''noneconomic damages'' means damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature.

(15) PUNITIVE DAMAGES.—The term ''punitive damages'' means damages awarded, for the purpose of punishment or deterrence, and not solely for compensatory purposes, against a health care provider or health care

institution. Punitive damages are neither economic nor noneconomic damages.

(16) RECOVERY.—The term ''recovery'' means the net sum recovered after deducting any disbursements or costs incurred in connection with prosecution or settlement of the claim, including all costs paid or advanced by any person. Costs of health care incurred by the plaintiff and the attorneys' office overhead costs or charges for legal services are not deductible disbursements or costs for such purpose.

(17) STATE.—The term ''State'' means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, the Trust Territory of the Pacific Islands, and any other territory or possession of the United States, or any political subdivision thereof.

SEC. _14. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.

(a) IN GENERAL.—Except as otherwise provided for in this section, the time for the commencement of a health care lawsuit shall be 3 years after the date of manifestation of injury or 1 year after the claimant discovers, or through the use of reasonable diligence should have discovered, the injury, whichever occurs first.

(b) GENERAL EXCEPTION.—The time for the commencement of a health care lawsuit shall not exceed 3 years after the date of manifestation of injury unless the tolling of time was delayed as a result of—

(1) fraud;

(2) intentional concealment; or

(3) the presence of a foreign body, which has no therapeutic or diagnostic purpose or effect, in the person of the injured person.

(c) MINORS.—An action by a minor shall be commenced within 3 years from the date of the alleged manifestation of injury except that if such minor is under the full age of 6 years, such action shall be commenced within 3 years of the manifestation of injury, or prior to the eighth birthday of the minor, whichever provides a longer period. Such time limitation shall be tolled for minors for any period during which a parent or guardian and a health care provider or health care institution have committed fraud or collusion in the failure to bring an action on behalf of the injured minor.

(d) RULE 11 SANCTIONS.—Whenever a Federal or State court determines (whether by motion of the parties or whether on the motion of the court) that there has been a violation of Rule 11 of the Federal Rules of Civil Procedure (or a similar violation of applicable State court rules) in a health care liability action to which this part applies, the court shall impose upon the attorneys, law firms, or pro se litigants that have violated Rule 11 or are responsible for the violation, an appropriate sanction, which shall include an order to pay the other party or parties for the reasonable expenses incurred as a direct result of the filing of the pleading, motion, or other paper that is the subject of the violation, including a reasonable attorneys' fee. Such sanction shall be sufficient to deter repetition of such conduct or comparable conduct by others similarly situated, and to compensate the party or parties injured by such conduct.

SEC. _15. COMPENSATING PATIENT INJURY.

(a) UNLIMITED AMOUNT OF DAMAGES FOR ACTUAL ECONOMIC LOSSES IN HEALTH CARE LAWSUITS.—In any health care lawsuit, nothing in this part shall limit the recovery by a claimant of the full amount of the available economic damages, notwithstanding the limitation contained in subsection (b).

(b) ADDITIONAL NONECONOMIC DAMAGES.—

(1) HEALTH CARE PROVIDERS.—In any health care lawsuit where final judgment is rendered against a health care provider, the amount of noneconomic damages recovered from the provider, if otherwise available under applicable Federal or State law, may be as much as $250,000, regardless of the number of parties other than a health care institution against whom the action is brought or the number of separate claims or actions brought with respect to the same occurrence.

(2) HEALTH CARE INSTITUTIONS.—

(A) SINGLE INSTITUTION.—In any health care lawsuit where final judgment is rendered against a single health care institution, the amount of noneconomic damages recovered from the institution, if otherwise available under applicable Federal or State law, may be as much as $250,000, regardless of the number of parties against whom the action is brought or the number of separate claims or actions brought with respect to the same occurrence.

(B) MULTIPLE INSTITUTIONS.—In any health care lawsuit where final judgment is rendered against more than one health care institution, the amount of noneconomic damages recovered from each institution, if otherwise available under applicable Federal or State law, may be as much as $250,000, regardless of the number of parties against whom the action is brought or the number of separate claims or actions brought with respect to the same occurrence, except that the total amount recovered from all such institutions in such lawsuit shall not exceed $500,000.

(c) NO DISCOUNT OF AWARD FOR NONECONOMIC DAMAGES.—In any health care lawsuit—

(1) an award for future noneconomic damages shall not be discounted to present value;

(2) the jury shall not be informed about the maximum award for noneconomic damages under subsection (b);

(3) an award for noneconomic damages in excess of the limitations provided for in subsection (b) shall be reduced either before the entry of judgment, or by amendment of the judgment after entry of judgment, and such reduction shall be made before accounting for any other reduction in damages required by law; and

(4) if separate awards are rendered for past and future noneconomic damages and the combined awards exceed the limitations described in subsection (b), the future noneconomic damages shall be reduced first.

(d) FAIR SHARE RULE.—In any health care lawsuit, each party shall be liable for that party's several share of any damages only and not for the share of any other person. Each party shall be liable only for the amount of damages allocated to such party in direct proportion to such party's percentage of responsibility. A separate judgment shall be rendered against each such party for the amount allocated to such party. For purposes of this section, the trier of fact shall determine the proportion of responsibility of each party for the claimant's harm.

SEC. _16. MAXIMIZING PATIENT RECOVERY.

(a) COURT SUPERVISION OF SHARE OF DAMAGES ACTUALLY PAID TO CLAIMANTS.—

(1) IN GENERAL.—In any health care lawsuit, the court shall supervise the arrangements for payment of damages to protect against conflicts of interest that may have the effect of reducing the amount of damages awarded that are actually paid to claimants.

(2) CONTINGENCY FEES.—

(A) IN GENERAL.—In any health care lawsuit in which the attorney for a party claims a financial stake in the outcome by virtue of a contingent fee, the court shall have the power to restrict the payment of a claimant's damage recovery to such attorney, and to redirect such damages to the claimant based upon the interests of justice and principles of equity.

(B) LIMITATION.—The total of all contingent fees for representing all claimants in a health care lawsuit shall not exceed the following limits:

(i) 40 percent of the first $50,000 recovered by the claimant(s).

(ii) 33⅓ percent of the next $50,000 recovered by the claimant(s).

(iii) 25 percent of the next $500,000 recovered by the claimant(s).

(iv) 15 percent of any amount by which the recovery by the claimant(s) is in excess of $600,000.

(b) APPLICABILITY.—

(1) IN GENERAL.—The limitations in subsection (a) shall apply whether the recovery is by judgment, settlement, mediation, arbitration, or any other form of alternative dispute resolution.

(2) MINORS.—In a health care lawsuit involving a minor or incompetent person, a court retains the authority to authorize or approve a fee that is less than the maximum permitted under this section.

(c) EXPERT WITNESSES.—

(1) REQUIREMENT.—No individual shall be qualified to testify as an expert witness concerning issues of negligence in any health care lawsuit against a defendant unless such individual—

(A) except as required under paragraph (2), is a health care professional who—

(i) is appropriately credentialed or licensed in 1 or more States to deliver health care services; and

(ii) typically treats the diagnosis or condition or provides the type of treatment under review; and

(B) can demonstrate by competent evidence that, as a result of training, education, knowledge, and experience in the evaluation, diagnosis, and treatment of the disease or injury which is the subject matter of the lawsuit against the defendant, the individual was substantially familiar with applicable standards of care and practice as they relate to the act or omission which is the subject of the lawsuit on the date of the incident.

(2) PHYSICIAN REVIEW.—In a health care lawsuit, if the claim of the plaintiff involved treatment that is recommended or provided by a physician (allopathic or osteopathic), an individual shall not be qualified to be an expert witness under this subsection with respect to issues of negligence concerning such treatment unless such individual is a physician.

(3) SPECIALTIES AND SUBSPECIALTIES.—With respect to a lawsuit described in paragraph (1), a court shall not permit an expert in one medical specialty or subspecialty to testify against a defendant in another medical specialty or subspecialty unless, in addition to a showing of substantial familiarity in accordance with paragraph (1)(B), there is a showing that the standards of care and practice in the two specialty or subspecialty fields are similar.

(4) LIMITATION.—The limitations in this subsection shall not apply to expert witnesses testifying as to the degree or permanency of medical or physical impairment.

SEC. _17. ADDITIONAL HEALTH BENEFITS.

(a) IN GENERAL.—The amount of any damages received by a claimant in any health care lawsuit shall be reduced by the court by the amount of any collateral source benefits to which the claimant is entitled, less any insurance premiums or other payments made by the claimant (or by the spouse, parent, child, or legal guardian of the claimant) to obtain or secure such benefits.

(b) PRESERVATION OF CURRENT LAW.—Where a payor of collateral source benefits has a right of recovery by reimbursement or

subrogation and such right is permitted under Federal or State law, subsection (a) shall not apply.

(c) APPLICATION OF PROVISION.—This section shall apply to any health care lawsuit that is settled or resolved by a fact finder.

SEC. __18. PUNITIVE DAMAGES.

(a) PUNITIVE DAMAGES PERMITTED.—

(1) IN GENERAL.—Punitive damages may, if otherwise available under applicable State or Federal law, be awarded against any person in a health care lawsuit only if it is proven by clear and convincing evidence that such person acted with malicious intent to injure the claimant, or that such person deliberately failed to avoid unnecessary injury that such person knew the claimant was substantially certain to suffer.

(2) FILING OF LAWSUIT.—No demand for punitive damages shall be included in a health care lawsuit as initially filed. A court may allow a claimant to file an amended pleading for punitive damages only upon a motion by the claimant and after a finding by the court, upon review of supporting and opposing affidavits or after a hearing, after weighing the evidence, that the claimant has established by a substantial probability that the claimant will prevail on the claim for punitive damages.

(3) SEPARATE PROCEEDING.—At the request of any party in a health care lawsuit, the trier of fact shall consider in a separate proceeding—

(A) whether punitive damages are to be awarded and the amount of such award; and

(B) the amount of punitive damages following a determination of punitive liability. If a separate proceeding is requested, evidence relevant only to the claim for punitive damages, as determined by applicable State law, shall be inadmissible in any proceeding to determine whether compensatory damages are to be awarded.

(4) LIMITATION WHERE NO COMPENSATORY DAMAGES ARE AWARDED.—In any health care lawsuit where no judgment for compensatory damages is rendered against a person, no punitive damages may be awarded with respect to the claim in such lawsuit against such person.

(b) DETERMINING AMOUNT OF PUNITIVE DAMAGES.—

(1) FACTORS CONSIDERED.—In determining the amount of punitive damages under this section, the trier of fact shall consider only the following:

(A) the severity of the harm caused by the conduct of such party;

(B) the duration of the conduct or any concealment of it by such party;

(C) the profitability of the conduct to such party;

(D) the number of products sold or medical procedures rendered for compensation, as the case may be, by such party, of the kind causing the harm complained of by the claimant;

(E) any criminal penalties imposed on such party, as a result of the conduct complained of by the claimant; and

(F) the amount of any civil fines assessed against such party as a result of the conduct complained of by the claimant.

(2) MAXIMUM AWARD.—The amount of punitive damages awarded in a health care lawsuit may not exceed an amount equal to two times the amount of economic damages awarded in the lawsuit or $250,000, whichever is greater. The jury shall not be informed of the limitation under the preceding sentence.

(c) LIABILITY OF HEALTH CARE PROVIDERS.—

(1) IN GENERAL.—A health care provider who prescribes, or who dispenses pursuant to a prescription, a drug, biological product, or medical device approved by the Food and Drug Administration, for an approved indication of the drug, biological product, or medical device, shall not be named as a party to a product liability lawsuit invoking such drug, biological product, or medical device and shall not be liable to a claimant in a class action lawsuit against the manufacturer, distributor, or product seller of such drug, biological product, or medical device.

(2) MEDICAL PRODUCT.—The term ''medical product'' means a drug or device intended for humans. The terms ''drug'' and ''device'' have the meanings given such terms in sections 201(g)(1) and 201(h) of the Federal Food, Drug and Cosmetic Act (21 U.S.C. 321), respectively, including any component or raw material used therein, but excluding health care services.

SEC. __19. AUTHORIZATION OF PAYMENT OF FUTURE DAMAGES TO CLAIMANTS IN HEALTH CARE LAWSUITS.

(a) IN GENERAL.—In any health care lawsuit, if an award of future damages, without reduction to present value, equaling or exceeding $50,000 is made against a party with sufficient insurance or other assets to fund a periodic payment of such a judgment, the court shall, at the request of any party, enter a judgment ordering that the future damages be paid by periodic payments in accordance with the Uniform Periodic Payment of Judgments Act promulgated by the National Conference of Commissioners on Uniform State Laws.

(b) APPLICABILITY.—This section applies to all actions which have not been first set for trial or retrial before the effective date of this part.

SEC. __20. EFFECT ON OTHER LAWS.

(a) GENERAL VACCINE INJURY.—

(1) IN GENERAL.—To the extent that title XXI of the Public Health Service Act establishes a Federal rule of law applicable to a civil action brought for a vaccine-related injury or death—

(A) this part shall not affect the application of the rule of law to such an action; and

(B) any rule of law prescribed by this part in conflict with a rule of law of such title XXI shall not apply to such action.

(2) EXCEPTION.—If there is an aspect of a civil action brought for a vaccine-related injury or death to which a Federal rule of law under title XXI of the Public Health Service Act does not apply, then this part or otherwise applicable law (as determined under this part) will apply to such aspect of such action.

(b) SMALLPOX VACCINE INJURY.—

(1) IN GENERAL.—To the extent that part C of title II of the Public Health Service Act establishes a Federal rule of law applicable to a civil action brought for a smallpox vaccine-related injury or death—

(A) this part shall not affect the application of the rule of law to such an action; and

(B) any rule of law prescribed by this part in conflict with a rule of law of such part C shall not apply to such action.

(2) EXCEPTION.—If there is an aspect of a civil action brought for a smallpox vaccine-related injury or death to which a Federal rule of law under part C of title II of the Public Health Service Act does not apply, then this part or otherwise applicable law (as determined under this part) will apply to such aspect of such action.

(c) OTHER FEDERAL LAW.—Except as provided in this section, nothing in this part shall be deemed to affect any defense available, or any limitation on liability that applies to, a defendant in a health care lawsuit or action under any other provision of Federal law.

SEC. __21. STATE FLEXIBILITY AND PROTECTION OF STATES' RIGHTS.

(a) HEALTH CARE LAWSUITS.—The provisions governing health care lawsuits set forth in this part shall preempt, subject to subsections (b) and (c), State law to the extent that State law prevents the application of any provisions of law established by or under this part. The provisions governing health care lawsuits set forth in this part supersede chapter 171 of title 28, United States Code, to the extent that such chapter—

(1) provides for a greater amount of damages or contingent fees, a longer period in which a health care lawsuit may be commenced, or a reduced applicability or scope of periodic payment of future damages, than provided in this part; or

(2) prohibits the introduction of evidence regarding collateral source benefits.

(b) PREEMPTION OF CERTAIN STATE LAWS.—No provision of this part shall be construed to preempt any State law (whether effective before, on, or after the date of the enactment of this part) that specifies a particular monetary amount of compensatory or punitive damages (or the total amount of damages) that may be awarded in a health care lawsuit, regardless of whether such monetary amount is greater or lesser than is provided for under this part, notwithstanding section __15(a).

(c) PROTECTION OF STATE'S RIGHTS AND OTHER LAWS.—

(1) IN GENERAL.—Any issue that is not governed by a provision of law established by or under this part (including the State standards of negligence) shall be governed by otherwise applicable Federal or State law.

(2) RULE OF CONSTRUCTION.—Nothing in this part shall be construed to—

(A) preempt or supersede any Federal or State law that imposes greater procedural or substantive protections (such as a shorter statute of limitations) for a health care provider or health care institution from liability, loss, or damages than those provided by this part;

(B) preempt or supercede any State law that permits and provides for the enforcement of any arbitration agreement related to a health care liability claim whether enacted prior to or after the date of enactment of this part;

(C) create a cause of action that is not otherwise available under Federal or State law; or

(D) affect the scope of preemption of any other Federal law.

SEC. __22. APPLICABILITY; EFFECTIVE DATE.

This part shall apply to any health care lawsuit brought in a Federal or State court, or subject to an alternative dispute resolution system, that is initiated on or after the date of the enactment of this part, except that any health care lawsuit arising from an injury occurring prior to the date of enactment of this part shall be governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

SA 3245. Mr. GRASSLEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

Subtitle __—Improved Patient Access and Medical Care

PART I—INCREASED MEDICAID PAYMENTS FOR PEDIATRIC CARE

SEC. __01. INCREASED PAYMENTS FOR PEDIATRIC CARE UNDER MEDICAID.

(a) IN GENERAL.—

(1) FEE-FOR-SERVICE PAYMENTS.—Section 1902 of the Social Security Act (42 U.S.C. 1396b), as amended by section 2001(b)(2), is amended—

(A) in subsection (a)(13)—

(i) by striking ''and'' at the end of subparagraph (A);

(ii) by adding ''and'' at the end of subparagraph (B); and

(iii) by adding at the end the following new subparagraph:

''(C) payment for pediatric care services (as defined in subsection (hh)(1)) furnished by hospitals or physicians (as defined in section 1861(r)) (or for services furnished by other health care professionals that would be pediatric care services under such subsection if furnished by a physician) at a rate not less than—

''(i) in the case of such services furnished by physicians (or professionals), 80 percent of the payment rate that would be applicable if the adjustment described in subsection (hh)(2) were to apply to such services and physicians or professionals (as the case may be) under part B of title XVIII (or, if there is no payment rate for such services under part B of title XVIII, the payment rate for the most comparable services, as determined by the Secretary in consultation with the Medicaid and CHIP Payment and Access Commission established under section 1900 and adjusted as appropriate for a pediatric population) for services furnished in 2010, 90 percent of such adjusted payment rate for services and physicians (or professionals) furnished in 2011, and 100 percent of such adjusted payment rate for services and hospitals or physicians (or professionals) furnished in 2012 and each subsequent year; and

''(ii) in the case of such services furnished by hospitals, 80 percent of the payment rate that would be applicable if such services were furnished under part A of title XVIII (or, if there is no payment rate for such services under part A of title XVIII, the payment rate for the most comparable services, as determined by the Secretary in consultation with the Medicaid and CHIP Payment and Access Commission established under section 1900 and adjusted as appropriate for a pediatric population) for services furnished in 2010, 90 percent of such payment rate for services furnished in 2011, and 100 percent of such payment rate for services furnished in 2012 and each subsequent year;''; and

(B) by adding at the end the following new subsection:

''(hh) INCREASED PAYMENT FOR PEDIATRIC CARE.—For purposes of subsection (a)(13)(C):

''(1) PEDIATRIC CARE SERVICES DEFINED.—The term 'pediatric care services' means evaluation and management services, without regard to the specialty of the physician or hospital furnishing the services, that are procedure codes (for services covered under title XVIII) for services in the category designated Evaluation and Management in the Healthcare Common Procedure Coding System (established by the Secretary under section 1848(c)(5) as of December 31, 2009, and as subsequently modified by the Secretary) and that are furnished to an individual who is enrolled in the State plan under this title who has not attained age 19. Such term includes procedure codes established by the Secretary, in consultation with the Medicaid and CHIP Payment and Access Commission established under section 1900, for services furnished under State plans under this title to individuals who have not attained age 19 and for which there is not an a procedure code (or a procedure code that the Secretary, in consultation with such Commission, determines is comparable) established under the Healthcare Common Procedure Coding System.

''(2) ADJUSTMENT.—The adjustment described in this paragraph is the substitution of 1.25 percent for the update otherwise provided under section 1848(d)(4) for each year beginning with 2010.''.

(2) UNDER MEDICAID MANAGED CARE PLANS.—Section 1932(f) of such Act (42 U.S.C. 1396u–2(f)) is amended—

(A) in the heading, by adding at the end the following: ''; ADEQUACY OF PAYMENT FOR PEDIATRIC CARE SERVICES''; and

(B) by inserting before the period at the end the following: ''and, in the case of pediatric care services described in section 1902(a)(13)(C), consistent with the minimum payment rates specified in such section (regardless of the manner in which such payments are made, including in the form of capitation or partial capitation)''.

(b) INCREASED FMAP.—Section 1905 of such Act (42 U.S.C. 1396d), as amended by sections 2006 and 4107(a)(2), is amended

(1) in the first sentence of subsection (b), by striking ''and'' before ''(4)'' and by inserting before the period at the end the following: '', and (5) 100 percent (for periods beginning with 2010) with respect to amounts described in subsection (cc)''; and

(2) by adding at the end the following new subsection:

''(cc) For purposes of section 1905(b)(5), the amounts described in this subsection are the following:

''(1)(A) The portion of the amounts expended for medical assistance for services described in section 1902(a)(13)(C) furnished on or after January 1, 2010, that is attributable to the amount by which the minimum payment rate required under such section (or, by application, section 1932(f)) exceeds the payment rate applicable to such services under the State plan as of the date of enactment of the Patient Protection and Affordable Care Act.

''(B) Subparagraph (A) shall not be construed as preventing the payment of Federal financial participation based on the Federal medical assistance percentage for amounts in excess of those specified under such subparagraph.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2010.

PART II—MEDICAL CARE ACCESS PROTECTION

SEC. __11. SHORT TITLE OF PART.

This part may be cited as the ''Medical Care Access Protection Act of 2009'' or the ''MCAP Act''.

SEC. __12. FINDINGS AND PURPOSE.

(a) FINDINGS.—

(1) EFFECT ON HEALTH CARE ACCESS AND COSTS.—Congress finds that our current civil justice system is adversely affecting patient access to health care services, better patient care, and cost-efficient health care, in that the health care liability system is a costly and ineffective mechanism for resolving claims of health care liability and compensating injured patients, and is a deterrent to the sharing of information among health care professionals which impedes efforts to improve patient safety and quality of care.

(2) EFFECT ON INTERSTATE COMMERCE.—Congress finds that the health care and insurance industries are industries affecting interstate commerce and the health care liability litigation systems existing throughout the United States are activities that affect interstate commerce by contributing to the high costs of health care and premiums for health care liability insurance purchased by health care system providers.

(3) EFFECT ON FEDERAL SPENDING.—Congress finds that the health care liability litigation systems existing throughout the United States have a significant effect on the amount, distribution, and use of Federal funds because of—

(A) the large number of individuals who receive health care benefits under programs operated or financed by the Federal Government;

(B) the large number of individuals who benefit because of the exclusion from Federal taxes of the amounts spent to provide them with health insurance benefits; and

(C) the large number of health care providers who provide items or services for which the Federal Government makes payments.

(b) PURPOSE.—It is the purpose of this part to implement reasonable, comprehensive, and effective health care liability reforms designed to—

(1) improve the availability of health care services in cases in which health care liability actions have been shown to be a factor in the decreased availability of services;

(2) reduce the incidence of ''defensive medicine'' and lower the cost of health care liability insurance, all of which contribute to the escalation of health care costs;

(3) ensure that persons with meritorious health care injury claims receive fair and adequate compensation, including reasonable noneconomic damages;

(4) improve the fairness and cost-effectiveness of our current health care liability system to resolve disputes over, and provide compensation for, health care liability by reducing uncertainty in the amount of compensation provided to injured individuals; and

(5) provide an increased sharing of information in the health care system which will reduce unintended injury and improve patient care.

SEC. __13. DEFINITIONS.

In this part:

(1) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term ''alternative dispute resolution system'' or ''ADR'' means a system that provides for the resolution of health care lawsuits in a manner other than through a civil action brought in a State or Federal court.

(2) CLAIMANT.—The term ''claimant'' means any person who brings a health care lawsuit, including a person who asserts or claims a right to legal or equitable contribution, indemnity or subrogation, arising out of a health care liability claim or action, and any person on whose behalf such a claim is asserted or such an action is brought, whether deceased, incompetent, or a minor.

(3) COLLATERAL SOURCE BENEFITS.—The term ''collateral source benefits'' means any amount paid or reasonably likely to be paid in the future to or on behalf of the claimant, or any service, product or other benefit provided or reasonably likely to be provided in the future to or on behalf of the claimant, as a result of the injury or wrongful death, pursuant to—

(A) any State or Federal health, sickness, income-disability, accident, or workers' compensation law;

(B) any health, sickness, income-disability, or accident insurance that provides health benefits or income-disability coverage;

(C) any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental, or income disability benefits; and

(D) any other publicly or privately funded program.

(4) COMPENSATORY DAMAGES.—The term ''compensatory damages'' means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products,

such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities, damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature. Such term includes economic damages and noneconomic damages, as such terms are defined in this section.

(5) CONTINGENT FEE.—The term ''contingent fee'' includes all compensation to any person or persons which is payable only if a recovery is effected on behalf of one or more claimants.

(6) ECONOMIC DAMAGES.—The term ''economic damages'' means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities.

(7) HEALTH CARE GOODS OR SERVICES.—The term ''health care goods or services'' means any goods or services provided by a health care institution, provider, or by any individual working under the supervision of a health care provider, that relates to the diagnosis, prevention, care, or treatment of any human disease or impairment, or the assessment of the health of human beings.

(8) HEALTH CARE INSTITUTION.—The term ''health care institution'' means any entity licensed under Federal or State law to provide health care services (including but not limited to ambulatory surgical centers, assisted living facilities, emergency medical services providers, hospices, hospitals and hospital systems, nursing homes, or other entities licensed to provide such services).

(9) HEALTH CARE LAWSUIT.—The term ''health care lawsuit'' means any health care liability claim concerning the provision of health care goods or services affecting interstate commerce, or any health care liability action concerning the provision of (or the failure to provide) health care goods or services affecting interstate commerce, brought in a State or Federal court or pursuant to an alternative dispute resolution system, against a health care provider or a health care institution regardless of the theory of liability on which the claim is based, or the number of claimants, plaintiffs, defendants, or other parties, or the number of claims or causes of action, in which the claimant alleges a health care liability claim.

(10) HEALTH CARE LIABILITY ACTION.—The term ''health care liability action'' means a civil action brought in a State or Federal Court or pursuant to an alternative dispute resolution system, against a health care provider or a health care institution regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action, in which the claimant alleges a health care liability claim.

(11) HEALTH CARE LIABILITY CLAIM.—The term ''health care liability claim'' means a demand by any person, whether or not pursuant to ADR, against a health care provider or health care institution, including third-party claims, cross-claims, counter-claims, or contribution claims, which are based upon the provision of, use of, or payment for (or the failure to provide, use, or pay for) health care services, regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action.

(12) HEALTH CARE PROVIDER.—

(A) IN GENERAL.—The term ''health care provider'' means any person (including but not limited to a physician (as defined by section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r)), registered nurse, dentist, podiatrist, pharmacist, chiropractor, or optometrist) required by State or Federal law to be licensed, registered, or certified to provide health care services, and being either so licensed, registered, or certified, or exempted from such requirement by other statute or regulation.

(B) TREATMENT OF CERTAIN PROFESSIONAL ASSOCIATIONS.—For purposes of this part, a professional association that is organized under State law by an individual physician or group of physicians, a partnership or limited liability partnership formed by a group of physicians, a nonprofit health corporation certified under State law, or a company formed by a group of physicians under State law shall be treated as a health care provider under subparagraph (A).

(13) MALICIOUS INTENT TO INJURE.—The term ''malicious intent to injure'' means intentionally causing or attempting to cause physical injury other than providing health care goods or services.

(14) NONECONOMIC DAMAGES.—The term ''noneconomic damages'' means damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature.

(15) PUNITIVE DAMAGES.—The term ''punitive damages'' means damages awarded, for the purpose of punishment or deterrence, and not solely for compensatory purposes, against a health care provider or health care institution. Punitive damages are neither economic nor noneconomic damages.

(16) RECOVERY.—The term ''recovery'' means the net sum recovered after deducting any disbursements or costs incurred in connection with prosecution or settlement of the claim, including all costs paid or advanced by any person. Costs of health care incurred by the plaintiff and the attorneys' office overhead costs or charges for legal services are not deductible disbursements or costs for such purpose.

(17) STATE.—The term ''State'' means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, the Trust Territory of the Pacific Islands, and any other territory or possession of the United States, or any political subdivision thereof.

SEC. __14. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.

(a) IN GENERAL.—Except as otherwise provided for in this section, the time for the commencement of a health care lawsuit shall be 3 years after the date of manifestation of injury or 1 year after the claimant discovers, or through the use of reasonable diligence should have discovered, the injury, whichever occurs first.

(b) GENERAL EXCEPTION.—The time for the commencement of a health care lawsuit shall not exceed 3 years after the date of manifestation of injury unless the tolling of time was delayed as a result of—

(1) fraud;

(2) intentional concealment; or

(3) the presence of a foreign body, which has no therapeutic or diagnostic purpose or effect, in the person of the injured person.

(c) MINORS.—An action by a minor shall be commenced within 3 years from the date of the alleged manifestation of injury except that if such minor is under the full age of 6 years, such action shall be commenced within 3 years of the manifestation of injury, or prior to the eighth birthday of the minor, whichever provides a longer period. Such time limitation shall be tolled for minors for any period during which a parent or guardian and a health care provider or health care institution have committed fraud or collusion in the failure to bring an action on behalf of the injured minor.

(d) RULE 11 SANCTIONS.—Whenever a Federal or State court determines (whether by motion of the parties or whether on the motion of the court) that there has been a violation of Rule 11 of the Federal Rules of Civil Procedure (or a similar violation of applicable State court rules) in a health care liability action to which this part applies, the court shall impose upon the attorneys, law firms, or pro se litigants that have violated Rule 11 or are responsible for the violation, an appropriate sanction, which shall include an order to pay the other party or parties for the reasonable expenses incurred as a direct result of the filing of the pleading, motion, or other paper that is the subject of the violation, including a reasonable attorneys' fee. Such sanction shall be sufficient to deter repetition of such conduct or comparable conduct by others similarly situated, and to compensate the party or parties injured by such conduct.

SEC. __15. COMPENSATING PATIENT INJURY.

(a) UNLIMITED AMOUNT OF DAMAGES FOR ACTUAL ECONOMIC LOSSES IN HEALTH CARE LAWSUITS.—In any health care lawsuit, nothing in this part shall limit the recovery by a claimant of the full amount of the available economic damages, notwithstanding the limitation contained in subsection (b).

(b) ADDITIONAL NONECONOMIC DAMAGES.—

(1) HEALTH CARE PROVIDERS.—In any health care lawsuit where final judgment is rendered against a health care provider, the amount of noneconomic damages recovered from the provider, if otherwise available under applicable Federal or State law, may be as much as $250,000, regardless of the number of parties other than a health care institution against whom the action is brought or the number of separate claims or actions brought with respect to the same occurrence.

(2) HEALTH CARE INSTITUTIONS.—

(A) SINGLE INSTITUTION.—In any health care lawsuit where final judgment is rendered against a single health care institution, the amount of noneconomic damages recovered from the institution, if otherwise available under applicable Federal or State law, may be as much as $250,000, regardless of the number of parties against whom the action is brought or the number of separate claims or actions brought with respect to the same occurrence.

(B) MULTIPLE INSTITUTIONS.—In any health care lawsuit where final judgment is rendered against more than one health care institution, the amount of noneconomic damages recovered from each institution, if otherwise available under applicable Federal or State law, may be as much as $250,000, regardless of the number of parties against whom the action is brought or the number of separate claims or actions brought with respect to the same occurrence, except that the total amount recovered from all such institutions in such lawsuit shall not exceed $500,000.

(c) NO DISCOUNT OF AWARD FOR NONECONOMIC DAMAGES.—In any health care lawsuit—

(1) an award for future noneconomic damages shall not be discounted to present value;

(2) the jury shall not be informed about the maximum award for noneconomic damages under subsection (b);

(3) an award for noneconomic damages in excess of the limitations provided for in subsection (b) shall be reduced either before the entry of judgment, or by amendment of the judgment after entry of judgment, and such reduction shall be made before accounting for any other reduction in damages required by law; and

(4) if separate awards are rendered for past and future noneconomic damages and the combined awards exceed the limitations described in subsection (b), the future noneconomic damages shall be reduced first.

(d) FAIR SHARE RULE.—In any health care lawsuit, each party shall be liable for that party's several share of any damages only and not for the share of any other person. Each party shall be liable only for the amount of damages allocated to such party in direct proportion to such party's percentage of responsibility. A separate judgment shall be rendered against each such party for the amount allocated to such party. For purposes of this section, the trier of fact shall determine the proportion of responsibility of each party for the claimant's harm.

SEC. __16. MAXIMIZING PATIENT RECOVERY.

(a) COURT SUPERVISION OF SHARE OF DAMAGES ACTUALLY PAID TO CLAIMANTS.—

(1) IN GENERAL.—In any health care lawsuit, the court shall supervise the arrangements for payment of damages to protect against conflicts of interest that may have the effect of reducing the amount of damages awarded that are actually paid to claimants.

(2) CONTINGENCY FEES.—

(A) IN GENERAL.—In any health care lawsuit in which the attorney for a party claims a financial stake in the outcome by virtue of a contingent fee, the court shall have the power to restrict the payment of a claimant's damage recovery to such attorney, and to redirect such damages to the claimant based upon the interests of justice and principles of equity.

(B) LIMITATION.—The total of all contingent fees for representing all claimants in a health care lawsuit shall not exceed the following limits:

(i) 40 percent of the first $50,000 recovered by the claimant(s).

(ii) 33⅓ percent of the next $50,000 recovered by the claimant(s).

(iii) 25 percent of the next $500,000 recovered by the claimant(s).

(iv) 15 percent of any amount by which the recovery by the claimant(s) is in excess of $600,000.

(b) APPLICABILITY.—

(1) IN GENERAL.—The limitations in subsection (a) shall apply whether the recovery is by judgment, settlement, mediation, arbitration, or any other form of alternative dispute resolution.

(2) MINORS.—In a health care lawsuit involving a minor or incompetent person, a court retains the authority to authorize or approve a fee that is less than the maximum permitted under this section.

(c) EXPERT WITNESSES.—

(1) REQUIREMENT.—No individual shall be qualified to testify as an expert witness concerning issues of negligence in any health care lawsuit against a defendant unless such individual—

(A) except as required under paragraph (2), is a health care professional who—

(i) is appropriately credentialed or licensed in 1 or more States to deliver health care services; and

(ii) typically treats the diagnosis or condition or provides the type of treatment under review; and

(B) can demonstrate by competent evidence that, as a result of training, education, knowledge, and experience in the evaluation, diagnosis, and treatment of the disease or injury which is the subject matter of the lawsuit against the defendant, the individual was substantially familiar with applicable standards of care and practice as they relate to the act or omission which is the subject of the lawsuit on the date of the incident.

(2) PHYSICIAN REVIEW.—In a health care lawsuit, if the claim of the plaintiff involved treatment that is recommended or provided by a physician (allopathic or osteopathic), an individual shall not be qualified to be an expert witness under this subsection with respect to issues of negligence concerning such treatment unless such individual is a physician.

(3) SPECIALTIES AND SUBSPECIALTIES.—With respect to a lawsuit described in paragraph (1), a court shall not permit an expert in one medical specialty or subspecialty to testify against a defendant in another medical specialty or subspecialty unless, in addition to a showing of substantial familiarity in accordance with paragraph (1)(B), there is a showing that the standards of care and practice in the two specialty or subspecialty fields are similar.

(4) LIMITATION.—The limitations in this subsection shall not apply to expert witnesses testifying as to the degree or permanency of medical or physical impairment.

SEC. __17. ADDITIONAL HEALTH BENEFITS.

(a) IN GENERAL.—The amount of any damages received by a claimant in any health care lawsuit shall be reduced by the court by the amount of any collateral source benefits to which the claimant is entitled, less any insurance premiums or other payments made by the claimant (or by the spouse, parent, child, or legal guardian of the claimant) to obtain or secure such benefits.

(b) PRESERVATION OF CURRENT LAW.—Where a payor of collateral source benefits has a right of recovery by reimbursement or subrogation and such right is permitted under Federal or State law, subsection (a) shall not apply.

(c) APPLICATION OF PROVISION.—This section shall apply to any health care lawsuit that is settled or resolved by a fact finder.

SEC. __18. PUNITIVE DAMAGES.

(a) PUNITIVE DAMAGES PERMITTED.—

(1) IN GENERAL.—Punitive damages may, if otherwise available under applicable State or Federal law, be awarded against any person in a health care lawsuit only if it is proven by clear and convincing evidence that such person acted with malicious intent to injure the claimant, or that such person deliberately failed to avoid unnecessary injury that such person knew the claimant was substantially certain to suffer.

(2) FILING OF LAWSUIT.—No demand for punitive damages shall be included in a health care lawsuit as initially filed. A court may allow a claimant to file an amended pleading for punitive damages only upon a motion by the claimant and after a finding by the court, upon review of supporting and opposing affidavits or after a hearing, after weighing the evidence, that the claimant has established by a substantial probability that the claimant will prevail on the claim for punitive damages.

(3) SEPARATE PROCEEDING.—At the request of any party in a health care lawsuit, the trier of fact shall consider in a separate proceeding—

(A) whether punitive damages are to be awarded and the amount of such award; and

(B) the amount of punitive damages following a determination of punitive liability.

If a separate proceeding is requested, evidence relevant only to the claim for punitive damages, as determined by applicable State law, shall be inadmissible in any proceeding to determine whether compensatory damages are to be awarded.

(4) LIMITATION WHERE NO COMPENSATORY DAMAGES ARE AWARDED.—In any health care lawsuit where no judgment for compensatory damages is rendered against a person, no punitive damages may be awarded with respect to the claim in such lawsuit against such person.

(b) DETERMINING AMOUNT OF PUNITIVE DAMAGES.—

(1) FACTORS CONSIDERED.—In determining the amount of punitive damages under this section, the trier of fact shall consider only the following:

(A) the severity of the harm caused by the conduct of such party;

(B) the duration of the conduct or any concealment of it by such party;

(C) the profitability of the conduct to such party;

(D) the number of products sold or medical procedures rendered for compensation, as the case may be, by such party, of the kind causing the harm complained of by the claimant;

(E) any criminal penalties imposed on such party, as a result of the conduct complained of by the claimant; and

(F) the amount of any civil fines assessed against such party as a result of the conduct complained of by the claimant.

(2) MAXIMUM AWARD.—The amount of punitive damages awarded in a health care lawsuit may not exceed an amount equal to two times the amount of economic damages awarded in the lawsuit or $250,000, whichever is greater. The jury shall not be informed of the limitation under the preceding sentence.

(c) LIABILITY OF HEALTH CARE PROVIDERS.—

(1) IN GENERAL.—A health care provider who prescribes, or who dispenses pursuant to a prescription, a drug, biological product, or medical device approved by the Food and Drug Administration, for an approved indication of the drug, biological product, or medical device, shall not be named as a party to a product liability lawsuit invoking such drug, biological product, or medical device and shall not be liable to a claimant in a class action lawsuit against the manufacturer, distributor, or product seller of such drug, biological product, or medical device.

(2) MEDICAL PRODUCT.—The term ''medical product'' means a drug or device intended for humans. The terms ''drug'' and ''device'' have the meanings given such terms in sections 201(g)(1) and 201(h) of the Federal Food, Drug and Cosmetic Act (21 U.S.C. 321), respectively, including any component or raw material used therein, but excluding health care services.

SEC. __19. AUTHORIZATION OF PAYMENT OF FUTURE DAMAGES TO CLAIMANTS IN HEALTH CARE LAWSUITS.

(a) IN GENERAL.—In any health care lawsuit, if an award of future damages, without reduction to present value, equaling or exceeding $50,000 is made against a party with sufficient insurance or other assets to fund a periodic payment of such a judgment, the court shall, at the request of any party, enter a judgment ordering that the future damages be paid by periodic payments in accordance with the Uniform Periodic Payment of Judgments Act promulgated by the National Conference of Commissioners on Uniform State Laws.

(b) APPLICABILITY.—This section applies to all actions which have not been first set for trial or retrial before the effective date of this part.

SEC. __20. EFFECT ON OTHER LAWS.

(a) GENERAL VACCINE INJURY.—

(1) IN GENERAL.—To the extent that title XXI of the Public Health Service Act establishes a Federal rule of law applicable to a civil action brought for a vaccine-related injury or death—

(A) this part shall not affect the application of the rule of law to such an action; and

(B) any rule of law prescribed by this part in conflict with a rule of law of such title XXI shall not apply to such action.

(2) EXCEPTION.—If there is an aspect of a civil action brought for a vaccine-related injury or death to which a Federal rule of law under title XXI of the Public Health Service Act does not apply, then this part or otherwise applicable law (as determined under this part) will apply to such aspect of such action.

(b) SMALLPOX VACCINE INJURY.—

(1) IN GENERAL.—To the extent that part C of title II of the Public Health Service Act establishes a Federal rule of law applicable to a civil action brought for a smallpox vaccine-related injury or death—

(A) this part shall not affect the application of the rule of law to such an action; and

(B) any rule of law prescribed by this part in conflict with a rule of law of such part C shall not apply to such action.

(2) EXCEPTION.—If there is an aspect of a civil action brought for a smallpox vaccine-related injury or death to which a Federal rule of law under part C of title II of the Public Health Service Act does not apply, then this part or otherwise applicable law (as determined under this part) will apply to such aspect of such action.

(c) OTHER FEDERAL LAW.—Except as provided in this section, nothing in this part shall be deemed to affect any defense available, or any limitation on liability that applies to, a defendant in a health care lawsuit or action under any other provision of Federal law.

SEC. __21. STATE FLEXIBILITY AND PROTECTION OF STATES' RIGHTS.

(a) HEALTH CARE LAWSUITS.—The provisions governing health care lawsuits set forth in this part shall preempt, subject to subsections (b) and (c), State law to the extent that State law prevents the application of any provisions of law established by or under this part. The provisions governing health care lawsuits set forth in this part supersede chapter 171 of title 28, United States Code, to the extent that such chapter—

(1) provides for a greater amount of damages or contingent fees, a longer period in which a health care lawsuit may be commenced, or a reduced applicability or scope of periodic payment of future damages, than provided in this part; or

(2) prohibits the introduction of evidence regarding collateral source benefits.

(b) PREEMPTION OF CERTAIN STATE LAWS.—No provision of this part shall be construed to preempt any State law (whether effective before, on, or after the date of the enactment of this part) that specifies a particular monetary amount of compensatory or punitive damages (or the total amount of damages) that may be awarded in a health care lawsuit, regardless of whether such monetary amount is greater or lesser than is provided for under this part, notwithstanding section __15(a).

(c) PROTECTION OF STATE'S RIGHTS AND OTHER LAWS.—

(1) IN GENERAL.—Any issue that is not governed by a provision of law established by or under this part (including the State standards of negligence) shall be governed by otherwise applicable Federal or State law.

(2) RULE OF CONSTRUCTION.—Nothing in this part shall be construed to—

(A) preempt or supersede any Federal or State law that imposes greater procedural or substantive protections (such as a shorter statute of limitations) for a health care provider or health care institution from liability, loss, or damages than those provided by this part;

(B) preempt or supercede any State law that permits and provides for the enforcement of any arbitration agreement related to a health care liability claim whether enacted prior to or after the date of enactment of this part;

(C) create a cause of action that is not otherwise available under Federal or State law; or

(D) affect the scope of preemption of any other Federal law.

SEC. __22. APPLICABILITY; EFFECTIVE DATE.

This part shall apply to any health care lawsuit brought in a Federal or State court, or subject to an alternative dispute resolution system, that is initiated on or after the date of the enactment of this part, except that any health care lawsuit arising from an injury occurring prior to the date of enactment of this part shall be governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

SA 3246. Mr. CASEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 974, between lines 9 and 10, insert the following:

SEC. 3315. EXPANSION OF THE DEFINITION OF A COVERED PART D DRUG UNDER THE MEDICARE PROGRAM.

(a) IN GENERAL.—Section 1860D–2(e)(1)(A) of the Social Security Act (42 U.S.C. 1395w–102(e)(1)(A)) is amended by inserting ''and disposable medical devices which reduce the side effects associated with the treatment of cancer'' after ''1927(k)(2)''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to drugs dispensed on or after January 1, 2011.

SA 3247. Mr. GRASSLEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 2074, after line 25, insert the following:

TITLE X—TO EXPAND ACCESS TO PRIMARY CARE SERVICES BY IMPROVING MEDICARE REIMBURSEMENT FOR PRIMARY CARE PRACTITIONERS WITH A SPECIALTY DESIGNATION OF NEUROLOGY

Subtitle A—Access to Primary Care Services

SEC. 10001. IMPROVED REIMBURSEMENT FOR PRIMARY CARE PRACTITIONERS WITH A SPECIALTY DESIGNATION OF NEUROLOGY.

Section 1833(x)(2)(A)(i)(I) of the Social Security Act, as added by section 5501, is amended by striking ''or pediatric medicine'' and inserting ''neurology, or pediatric medicine''.

Subtitle B—Medical Care Access Protection

SEC. 10101. SHORT TITLE.

This subtitle may be cited as the ''Medical Care Access Protection Act of 2009'' or the ''MCAP Act''.

SEC. 10102. FINDINGS AND PURPOSE.

(a) FINDINGS.—

(1) EFFECT ON HEALTH CARE ACCESS AND COSTS.—Congress finds that our current civil justice system is adversely affecting patient access to health care services, better patient care, and cost-efficient health care, in that the health care liability system is a costly and ineffective mechanism for resolving claims of health care liability and compensating injured patients, and is a deterrent to the sharing of information among health care professionals which impedes efforts to improve patient safety and quality of care.

(2) EFFECT ON INTERSTATE COMMERCE.—Congress finds that the health care and insurance industries are industries affecting interstate commerce and the health care liability litigation systems existing throughout the United States are activities that affect interstate commerce by contributing to the high costs of health care and premiums for health care liability insurance purchased by health care system providers.

(3) EFFECT ON FEDERAL SPENDING.—Congress finds that the health care liability litigation systems existing throughout the United States have a significant effect on the amount, distribution, and use of Federal funds because of—

(A) the large number of individuals who receive health care benefits under programs operated or financed by the Federal Government;

(B) the large number of individuals who benefit because of the exclusion from Federal taxes of the amounts spent to provide them with health insurance benefits; and

(C) the large number of health care providers who provide items or services for which the Federal Government makes payments.

(b) PURPOSE.—It is the purpose of this subtitle to implement reasonable, comprehensive, and effective health care liability reforms designed to—

(1) improve the availability of health care services in cases in which health care liability actions have been shown to be a factor in the decreased availability of services;

(2) reduce the incidence of ''defensive medicine'' and lower the cost of health care liability insurance, all of which contribute to the escalation of health care costs;

(3) ensure that persons with meritorious health care injury claims receive fair and adequate compensation, including reasonable noneconomic damages;

(4) improve the fairness and cost-effectiveness of our current health care liability system to resolve disputes over, and provide compensation for, health care liability by reducing uncertainty in the amount of compensation provided to injured individuals; and

(5) provide an increased sharing of information in the health care system which will reduce unintended injury and improve patient care.

SEC. 10103. DEFINITIONS.

In this subtitle:

(1) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term ''alternative dispute resolution system'' or ''ADR'' means a system that provides for the resolution of health care lawsuits in a manner other than through a civil action brought in a State or Federal court.

(2) CLAIMANT.—The term ''claimant'' means any person who brings a health care lawsuit, including a person who asserts or claims a right to legal or equitable contribution, indemnity or subrogation, arising out of a health care liability claim or action, and any person on whose behalf such a claim is asserted or such an action is brought, whether deceased, incompetent, or a minor.

(3) COLLATERAL SOURCE BENEFITS.—The term ''collateral source benefits'' means any

amount paid or reasonably likely to be paid in the future to or on behalf of the claimant, or any service, product or other benefit provided or reasonably likely to be provided in the future to or on behalf of the claimant, as a result of the injury or wrongful death, pursuant to—

(A) any State or Federal health, sickness, income-disability, accident, or workers' compensation law;

(B) any health, sickness, income-disability, or accident insurance that provides health benefits or income-disability coverage;

(C) any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental, or income disability benefits; and

(D) any other publicly or privately funded program.

(4) COMPENSATORY DAMAGES.—The term ''compensatory damages'' means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities, damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature. Such term includes economic damages and noneconomic damages, as such terms are defined in this section.

(5) CONTINGENT FEE.—The term ''contingent fee'' includes all compensation to any person or persons which is payable only if a recovery is effected on behalf of one or more claimants.

(6) ECONOMIC DAMAGES.—The term ''economic damages'' means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities.

(7) HEALTH CARE GOODS OR SERVICES.—The term ''health care goods or services'' means any goods or services provided by a health care institution, provider, or by any individual working under the supervision of a health care provider, that relates to the diagnosis, prevention, care, or treatment of any human disease or impairment, or the assessment of the health of human beings.

(8) HEALTH CARE INSTITUTION.—The term ''health care institution'' means any entity licensed under Federal or State law to provide health care services (including but not limited to ambulatory surgical centers, assisted living facilities, emergency medical services providers, hospices, hospitals and hospital systems, nursing homes, or other entities licensed to provide such services).

(9) HEALTH CARE LAWSUIT.—The term ''health care lawsuit'' means any health care liability claim concerning the provision of health care goods or services affecting interstate commerce, or any health care liability action concerning the provision of (or the failure to provide) health care goods or services affecting interstate commerce, brought in a State or Federal court or pursuant to an alternative dispute resolution system, against a health care provider or a health care institution regardless of the theory of liability on which the claim is based, or the number of claimants, plaintiffs, defendants, or other parties, or the number of claims or causes of action, in which the claimant alleges a health care liability claim.

(10) HEALTH CARE LIABILITY ACTION.—The term ''health care liability action'' means a civil action brought in a State or Federal Court or pursuant to an alternative dispute resolution system, against a health care provider or a health care institution regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action, in which the claimant alleges a health care liability claim.

(11) HEALTH CARE LIABILITY CLAIM.—The term ''health care liability claim'' means a demand by any person, whether or not pursuant to ADR, against a health care provider or health care institution, including third-party claims, cross-claims, counter-claims, or contribution claims, which are based upon the provision of, use of, or payment for (or the failure to provide, use, or pay for) health care services, regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action.

(12) HEALTH CARE PROVIDER.—

(A) IN GENERAL.—The term ''health care provider'' means any person (including but not limited to a physician (as defined by section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r)), registered nurse, dentist, podiatrist, pharmacist, chiropractor, or optometrist) required by State or Federal law to be licensed, registered, or certified to provide health care services, and being either so licensed, registered, or certified, or exempted from such requirement by other statute or regulation.

(B) TREATMENT OF CERTAIN PROFESSIONAL ASSOCIATIONS.—For purposes of this subtitle, a professional association that is organized under State law by an individual physician or group of physicians, a partnership or limited liability partnership formed by a group of physicians, a nonprofit health corporation certified under State law, or a company formed by a group of physicians under State law shall be treated as a health care provider under subparagraph (A).

(13) MALICIOUS INTENT TO INJURE.—The term ''malicious intent to injure'' means intentionally causing or attempting to cause physical injury other than providing health care goods or services.

(14) NONECONOMIC DAMAGES.—The term ''noneconomic damages'' means damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature.

(15) PUNITIVE DAMAGES.—The term ''punitive damages'' means damages awarded, for the purpose of punishment or deterrence, and not solely for compensatory purposes, against a health care provider or health care institution. Punitive damages are neither economic nor noneconomic damages.

(16) RECOVERY.—The term ''recovery'' means the net sum recovered after deducting any disbursements or costs incurred in connection with prosecution or settlement of the claim, including all costs paid or advanced by any person. Costs of health care incurred by the plaintiff and the attorneys' office overhead costs or charges for legal services are not deductible disbursements or costs for such purpose.

(17) STATE.—The term ''State'' means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, the Trust Territory of the Pacific Islands, and any other territory or possession of the United States, or any political subdivision thereof.

SEC. 10104. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.

(a) IN GENERAL.—Except as otherwise provided for in this section, the time for the commencement of a health care lawsuit shall be 3 years after the date of manifestation of injury or 1 year after the claimant discovers, or through the use of reasonable diligence should have discovered, the injury, whichever occurs first.

(b) GENERAL EXCEPTION.—The time for the commencement of a health care lawsuit shall not exceed 3 years after the date of manifestation of injury unless the tolling of time was delayed as a result of—

(1) fraud;

(2) intentional concealment; or

(3) the presence of a foreign body, which has no therapeutic or diagnostic purpose or effect, in the person of the injured person.

(c) MINORS.—An action by a minor shall be commenced within 3 years from the date of the alleged manifestation of injury except that if such minor is under the full age of 6 years, such action shall be commenced within 3 years of the manifestation of injury, or prior to the eighth birthday of the minor, whichever provides a longer period. Such time limitation shall be tolled for minors for any period during which a parent or guardian and a health care provider or health care institution have committed fraud or collusion in the failure to bring an action on behalf of the injured minor.

(d) RULE 11 SANCTIONS.—Whenever a Federal or State court determines (whether by motion of the parties or whether on the motion of the court) that there has been a violation of Rule 11 of the Federal Rules of Civil Procedure (or a similar violation of applicable State court rules) in a health care liability action to which this subtitle applies, the court shall impose upon the attorneys, law firms, or pro se litigants that have violated Rule 11 or are responsible for the violation, an appropriate sanction, which shall include an order to pay the other party or parties for the reasonable expenses incurred as a direct result of the filing of the pleading, motion, or other paper that is the subject of the violation, including a reasonable attorneys' fee. Such sanction shall be sufficient to deter repetition of such conduct or comparable conduct by others similarly situated, and to compensate the party or parties injured by such conduct.

SEC. 10105. COMPENSATING PATIENT INJURY.

(a) UNLIMITED AMOUNT OF DAMAGES FOR ACTUAL ECONOMIC LOSSES IN HEALTH CARE LAWSUITS.—In any health care lawsuit, nothing in this subtitle shall limit the recovery by a claimant of the full amount of the available economic damages, notwithstanding the limitation contained in subsection (b).

(b) ADDITIONAL NONECONOMIC DAMAGES.—

(1) HEALTH CARE PROVIDERS.—In any health care lawsuit where final judgment is rendered against a health care provider, the amount of noneconomic damages recovered from the provider, if otherwise available under applicable Federal or State law, may be as much as $250,000, regardless of the number of parties other than a health care institution against whom the action is brought or the number of separate claims or actions brought with respect to the same occurrence.

(2) HEALTH CARE INSTITUTIONS.—

(A) SINGLE INSTITUTION.—In any health care lawsuit where final judgment is rendered against a single health care institution, the amount of noneconomic damages recovered from the institution, if otherwise available under applicable Federal or State

law, may be as much as $250,000, regardless of the number of parties against whom the action is brought or the number of separate claims or actions brought with respect to the same occurrence.

(B) MULTIPLE INSTITUTIONS.—In any health care lawsuit where final judgment is rendered against more than one health care institution, the amount of noneconomic damages recovered from each institution, if otherwise available under applicable Federal or State law, may be as much as $250,000, regardless of the number of parties against whom the action is brought or the number of separate claims or actions brought with respect to the same occurrence, except that the total amount recovered from all such institutions in such lawsuit shall not exceed $500,000.

(c) NO DISCOUNT OF AWARD FOR NONECONOMIC DAMAGES.—In any health care lawsuit—

(1) an award for future noneconomic damages shall not be discounted to present value;

(2) the jury shall not be informed about the maximum award for noneconomic damages under subsection (b);

(3) an award for noneconomic damages in excess of the limitations provided for in subsection (b) shall be reduced either before the entry of judgment, or by amendment of the judgment after entry of judgment, and such reduction shall be made before accounting for any other reduction in damages required by law; and

(4) if separate awards are rendered for past and future noneconomic damages and the combined awards exceed the limitations described in subsection (b), the future noneconomic damages shall be reduced first.

(d) FAIR SHARE RULE.—In any health care lawsuit, each party shall be liable for that party's several share of any damages only and not for the share of any other person. Each party shall be liable only for the amount of damages allocated to such party in direct proportion to such party's percentage of responsibility. A separate judgment shall be rendered against each such party for the amount allocated to such party. For purposes of this section, the trier of fact shall determine the proportion of responsibility of each party for the claimant's harm.

SEC. 10106. MAXIMIZING PATIENT RECOVERY.

(a) COURT SUPERVISION OF SHARE OF DAMAGES ACTUALLY PAID TO CLAIMANTS.—

(1) IN GENERAL.—In any health care lawsuit, the court shall supervise the arrangements for payment of damages to protect against conflicts of interest that may have the effect of reducing the amount of damages awarded that are actually paid to claimants.

(2) CONTINGENCY FEES.—

(A) IN GENERAL.—In any health care lawsuit in which the attorney for a party claims a financial stake in the outcome by virtue of a contingent fee, the court shall have the power to restrict the payment of a claimant's damage recovery to such attorney, and to redirect such damages to the claimant based upon the interests of justice and principles of equity.

(B) LIMITATION.—The total of all contingent fees for representing all claimants in a health care lawsuit shall not exceed the following limits:

(i) 40 percent of the first $50,000 recovered by the claimant(s).

(ii) 33⅓ percent of the next $50,000 recovered by the claimant(s).

(iii) 25 percent of the next $500,000 recovered by the claimant(s).

(iv) 15 percent of any amount by which the recovery by the claimant(s) is in excess of $600,000.

(b) APPLICABILITY.—

(1) IN GENERAL.—The limitations in subsection (a) shall apply whether the recovery is by judgment, settlement, mediation, arbitration, or any other form of alternative dispute resolution.

(2) MINORS.—In a health care lawsuit involving a minor or incompetent person, a court retains the authority to authorize or approve a fee that is less than the maximum permitted under this section.

(c) EXPERT WITNESSES.—

(1) REQUIREMENT.—No individual shall be qualified to testify as an expert witness concerning issues of negligence in any health care lawsuit against a defendant unless such individual—

(A) except as required under paragraph (2), is a health care professional who—

(i) is appropriately credentialed or licensed in 1 or more States to deliver health care services; and

(ii) typically treats the diagnosis or condition or provides the type of treatment under review; and

(B) can demonstrate by competent evidence that, as a result of training, education, knowledge, and experience in the evaluation, diagnosis, and treatment of the disease or injury which is the subject matter of the lawsuit against the defendant, the individual was substantially familiar with applicable standards of care and practice as they relate to the act or omission which is the subject of the lawsuit on the date of the incident.

(2) PHYSICIAN REVIEW.—In a health care lawsuit, if the claim of the plaintiff involved treatment that is recommended or provided by a physician (allopathic or osteopathic), an individual shall not be qualified to be an expert witness under this subsection with respect to issues of negligence concerning such treatment unless such individual is a physician.

(3) SPECIALTIES AND SUBSPECIALTIES.—With respect to a lawsuit described in paragraph (1), a court shall not permit an expert in one medical specialty or subspecialty to testify against a defendant in another medical specialty or subspecialty unless, in addition to a showing of substantial familiarity in accordance with paragraph (1)(B), there is a showing that the standards of care and practice in the two specialty or subspecialty fields are similar.

(4) LIMITATION.—The limitations in this subsection shall not apply to expert witnesses testifying as to the degree or permanency of medical or physical impairment.

SEC. 10107. ADDITIONAL HEALTH BENEFITS.

(a) IN GENERAL.—The amount of any damages received by a claimant in any health care lawsuit shall be reduced by the court by the amount of any collateral source benefits to which the claimant is entitled, less any insurance premiums or other payments made by the claimant (or by the spouse, parent, child, or legal guardian of the claimant) to obtain or secure such benefits.

(b) PRESERVATION OF CURRENT LAW.—Where a payor of collateral source benefits has a right of recovery by reimbursement or subrogation and such right is permitted under Federal or State law, subsection (a) shall not apply.

(c) APPLICATION OF PROVISION.—This section shall apply to any health care lawsuit that is settled or resolved by a fact finder.

SEC. 10108. PUNITIVE DAMAGES.

(a) PUNITIVE DAMAGES PERMITTED.—

(1) IN GENERAL.—Punitive damages may, if otherwise available under applicable State or Federal law, be awarded against any person in a health care lawsuit only if it is proven by clear and convincing evidence that such person acted with malicious intent to injure the claimant, or that such person deliberately failed to avoid unnecessary injury that such person knew the claimant was substantially certain to suffer.

(2) FILING OF LAWSUIT.—No demand for punitive damages shall be included in a health care lawsuit as initially filed. A court may allow a claimant to file an amended pleading for punitive damages only upon a motion by the claimant and after a finding by the court, upon review of supporting and opposing affidavits or after a hearing, after weighing the evidence, that the claimant has established by a substantial probability that the claimant will prevail on the claim for punitive damages.

(3) SEPARATE PROCEEDING.—At the request of any party in a health care lawsuit, the trier of fact shall consider in a separate proceeding—

(A) whether punitive damages are to be awarded and the amount of such award; and

(B) the amount of punitive damages following a determination of punitive liability. If a separate proceeding is requested, evidence relevant only to the claim for punitive damages, as determined by applicable State law, shall be inadmissible in any proceeding to determine whether compensatory damages are to be awarded.

(4) LIMITATION WHERE NO COMPENSATORY DAMAGES ARE AWARDED.—In any health care lawsuit where no judgment for compensatory damages is rendered against a person, no punitive damages may be awarded with respect to the claim in such lawsuit against such person.

(b) DETERMINING AMOUNT OF PUNITIVE DAMAGES.—

(1) FACTORS CONSIDERED.—In determining the amount of punitive damages under this section, the trier of fact shall consider only the following:

(A) the severity of the harm caused by the conduct of such party;

(B) the duration of the conduct or any concealment of it by such party;

(C) the profitability of the conduct to such party;

(D) the number of products sold or medical procedures rendered for compensation, as the case may be, by such party, of the kind causing the harm complained of by the claimant;

(E) any criminal penalties imposed on such party, as a result of the conduct complained of by the claimant; and

(F) the amount of any civil fines assessed against such party as a result of the conduct complained of by the claimant.

(2) MAXIMUM AWARD.—The amount of punitive damages awarded in a health care lawsuit may not exceed an amount equal to two times the amount of economic damages awarded in the lawsuit or $250,000, whichever is greater. The jury shall not be informed of the limitation under the preceding sentence.

(c) LIABILITY OF HEALTH CARE PROVIDERS.—

(1) IN GENERAL.—A health care provider who prescribes, or who dispenses pursuant to a prescription, a drug, biological product, or medical device approved by the Food and Drug Administration, for an approved indication of the drug, biological product, or medical device, shall not be named as a party to a product liability lawsuit invoking such drug, biological product, or medical device and shall not be liable to a claimant in a class action lawsuit against the manufacturer, distributor, or product seller of such drug, biological product, or medical device.

(2) MEDICAL PRODUCT.—The term ''medical product'' means a drug or device intended for humans. The terms ''drug'' and ''device'' have the meanings given such terms in sections 201(g)(1) and 201(h) of the Federal Food, Drug and Cosmetic Act (21 U.S.C. 321), respectively, including any component or raw material used therein, but excluding health care services.

SEC. 10109. AUTHORIZATION OF PAYMENT OF FUTURE DAMAGES TO CLAIMANTS IN HEALTH CARE LAWSUITS.

(a) IN GENERAL.—In any health care lawsuit, if an award of future damages, without reduction to present value, equaling or exceeding $50,000 is made against a party with sufficient insurance or other assets to fund a periodic payment of such a judgment, the court shall, at the request of any party, enter a judgment ordering that the future damages be paid by periodic payments in accordance with the Uniform Periodic Payment of Judgments Act promulgated by the National Conference of Commissioners on Uniform State Laws.

(b) APPLICABILITY.—This section applies to all actions which have not been first set for trial or retrial before the effective date of this subtitle.

SEC. 10110. EFFECT ON OTHER LAWS.

(a) GENERAL VACCINE INJURY.—

(1) IN GENERAL.—To the extent that title XXI of the Public Health Service Act establishes a Federal rule of law applicable to a civil action brought for a vaccine-related injury or death—

(A) this subtitle shall not affect the application of the rule of law to such an action; and

(B) any rule of law prescribed by this subtitle in conflict with a rule of law of such title XXI shall not apply to such action.

(2) EXCEPTION.—If there is an aspect of a civil action brought for a vaccine-related injury or death to which a Federal rule of law under title XXI of the Public Health Service Act does not apply, then this subtitle or otherwise applicable law (as determined under this subtitle) will apply to such aspect of such action.

(b) SMALLPOX VACCINE INJURY.—

(1) IN GENERAL.—To the extent that part C of title II of the Public Health Service Act establishes a Federal rule of law applicable to a civil action brought for a smallpox vaccine-related injury or death—

(A) this subtitle shall not affect the application of the rule of law to such an action; and

(B) any rule of law prescribed by this subtitle in conflict with a rule of law of such part C shall not apply to such action.

(2) EXCEPTION.—If there is an aspect of a civil action brought for a smallpox vaccine-related injury or death to which a Federal rule of law under part C of title II of the Public Health Service Act does not apply, then this subtitle or otherwise applicable law (as determined under this subtitle) will apply to such aspect of such action.

(c) OTHER FEDERAL LAW.—Except as provided in this section, nothing in this subtitle shall be deemed to affect any defense available, or any limitation on liability that applies to, a defendant in a health care lawsuit or action under any other provision of Federal law.

SEC. 10111. STATE FLEXIBILITY AND PROTECTION OF STATES' RIGHTS.

(a) HEALTH CARE LAWSUITS.—The provisions governing health care lawsuits set forth in this subtitle shall preempt, subject to subsections (b) and (c), State law to the extent that State law prevents the application of any provisions of law established by or under this subtitle. The provisions governing health care lawsuits set forth in this subtitle supersede chapter 171 of title 28, United States Code, to the extent that such chapter—

(1) provides for a greater amount of damages or contingent fees, a longer period in which a health care lawsuit may be commenced, or a reduced applicability or scope of periodic payment of future damages, than provided in this subtitle; or

(2) prohibits the introduction of evidence regarding collateral source benefits.

(b) PREEMPTION OF CERTAIN STATE LAWS.—No provision of this subtitle shall be construed to preempt any State law (whether effective before, on, or after the date of the enactment of this Act) that specifies a particular monetary amount of compensatory or punitive damages (or the total amount of damages) that may be awarded in a health care lawsuit, regardless of whether such monetary amount is greater or lesser than is provided for under this subtitle, notwithstanding section 10105(a).

(c) PROTECTION OF STATE'S RIGHTS AND OTHER LAWS.—

(1) IN GENERAL.—Any issue that is not governed by a provision of law established by or under this subtitle (including the State standards of negligence) shall be governed by otherwise applicable Federal or State law.

(2) RULE OF CONSTRUCTION.—Nothing in this subtitle shall be construed to—

(A) preempt or supersede any Federal or State law that imposes greater procedural or substantive protections (such as a shorter statute of limitations) for a health care provider or health care institution from liability, loss, or damages than those provided by this subtitle;

(B) preempt or supercede any State law that permits and provides for the enforcement of any arbitration agreement related to a health care liability claim whether enacted prior to or after the date of enactment of this Act;

(C) create a cause of action that is not otherwise available under Federal or State law; or

(D) affect the scope of preemption of any other Federal law.

SEC. 10112. APPLICABILITY; EFFECTIVE DATE.

This subtitle shall apply to any health care lawsuit brought in a Federal or State court, or subject to an alternative dispute resolution system, that is initiated on or after the date of the enactment of this Act, except that any health care lawsuit arising from an injury occurring prior to the date of enactment of this Act shall be governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

SA 3248. Mr. REID proposed an amendment to the bill H.R. 3326, making appropriations for the Department of Defense for the fiscal year ending September 30, 2010, and for other purposes; as follows:

At the end of the House Amendment, insert the following:

The provisions of this Act shall become effective 5 days after enactment.

SA 3249. Mr. REID proposed an amendment to the bill H.R. 3326, making appropriations for the Department of Defense for the fiscal year ending September 30, 2010, and for other purposes; as follows:

At the end, insert the following:

The Appropriations Committee is requested to study the impact of any delay in implementing the provisions of the Act on service members families.

SA 3250. Mr. REID proposed an amendment SA 3249 proposed by Mr. REID to the bill H.R. 3326, making appropriations for the Department of Defense for the fiscal year ending September 30, 2010, and for other purposes; as follows:

At the end, add the following:

''and the health care provided to those service members.''

SA 3251. Mr. REID proposed an amendment to amendment SA 3250 proposed by Mr. REID to the amendment SA 3249 proposed by Mr. REID to the bill H.R. 3326, making appropriations for the Department of Defense for the fiscal year ending September 30, 2010, and for other purposes; as follows:

At the end, add the following:

''and the children of service members.''

SA 3252. Mr. REID proposed an amendment to amendment SA 3248 proposed by Mr. REID to the bill H.R. 3326, making appropriations for the Department of Defense for the fiscal year ending September 30, 2010, and for other purposes; as follows:

Strike ''5 days'' and insert ''1 day''.

SA 3253. Ms. MURKOWSKI submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 816, after line 20, insert the following:

SEC. 3115. INCREASING THE LIMITATION ON CHARGES FOR PHYSICIANS' SERVICES UNDER THE MEDICARE PROGRAM.

(a) IN GENERAL.—Section 1848(g)(2)(C) of the Social Security Act (42 U.S.C. 1395w–4(g)(2)(C)) is amended by striking ''115 percent'' and all that follows through the period at the end and inserting ''the greater of—

''(i) 115 percent of the recognized payment amount under this part for nonparticipating physicians or for nonparticipating suppliers or other persons; or

''(ii) the average private insurance reimbursement rate for the item or service (as determined by the Secretary for that geographic practice cost index area).''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to items and services furnished on or after the date of the enactment of this Act.

SA 3254. Ms. MURKOWSKI submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 816, after line 20, insert the following:

SEC. 3115. ALLOWING INDIVIDUALS TO CHOOSE TO OPT OUT OF THE MEDICARE PART A BENEFIT.

Notwithstanding any other provision of law, in the case of an individual who elects to opt-out of benefits under part A of title XVIII of the Social Security Act, such individual shall not be required to—

(1) opt-out of benefits under title II of such Act as a condition for making such election; and

(2) repay any amount paid under such part A for items and services furnished prior to making such election.

SA 3255. Ms. MURKOWSKI submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place in title II, insert the following:

SEC. ___. MEDICAL MALPRACTICE REFORM.

Notwithstanding any other provision of this Act, a State that receives Federal funds under any amendment made by this Act to the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) to increase eligibility for participation in such program, shall implement reforms in the State medical malpractice litigation system that are designed to achieve cost savings through the development and implementation of alternatives to tort litigation.

SA 3256. Mr. BENNET submitted an amendment intended to be proposed by him to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. LONG-TERM FISCAL ACCOUNTABILITY.

(a) PURPOSE.—The purpose of this section is—

(1) to provide a fail-safe mechanism for ensuring that actual budgetary savings from this Act equal or exceed initial estimates of such savings;

(2) to create expedited procedures for Congress to consider legislative changes to increase savings to at least the initial estimate of this Act if actual budgetary savings are less than initial estimates; and

(3) to ensure that additional budget savings will further extend the solvency of the HI Trust Fund, lower premiums and other out-of-pocket costs for Medicare beneficiaries, and reduce the national debt.

(b) DEFINITIONS.—For the purposes of this section:

(1) BUDGETARY EFFECTS.—The term ''budgetary effects'' refers to the sum of the spending reductions and revenue increases for the period 2010 through 2019 from this Act less the sum of the spending increases and revenue reductions resulting from this Act for the same time period. The calculation shall not include an estimate of the change in federal interest payments.

(2) FEDERAL BUDGETARY COMMITMENT TO HEALTH CARE.—The term ''Federal budgetary commitment to health care'' refers to the sum of net Federal outlays for all Federal programs and tax preferences for health care.

(3) OMB PROPOSAL.—The term ''OMB proposal'' refers to the proposed legislative language and such proposal as subsequently modified, if modified by amendment in either House required under subsection (e)(2)(C) to carry out recommendations pursuant to subsection (e)(2)(A).

(4) SAVINGS TARGET.—The term ''savings target'' refers to the net total provided under subsection (d)(1) for the period 2010 through 2019.

(c) CBO ADVISORY REPORTS.—Starting on October 1, 2012, and every 2 years thereafter, through October 1, 2018, not later than 60 days after the start of the fiscal year, the Congressional Budget Office (CBO) shall submit an updated advisory report to Congress and the President. The updated report shall include a detailed estimate of the budgetary effects of this Act based on the information available for the period 2010 through 2019, as well as information on the budgetary effects for the period 2020 through 2029.

(d) OMB COST ESTIMATE REPORTS.—

(1) INITIAL COST ESTIMATE REPORT.—Not later than 60 days after the date of enactment of this Act, the Director of the Office of Management and Budget (OMB) shall submit to Congress a report containing an estimate of the budgetary effects of this Act for 2010 through 2019, as well as information on the budgetary effects for 2020 through 2029. The estimate of net savings produced by this Act for the period 2010 through 2019 period shall serve as the savings target for future cost estimate reports, provided that the OMB estimate is not less than the final CBO estimate of net savings produced by this Act made by CBO prior to its enactment. If the savings estimated by OMB is less than the amount estimated by the CBO, then the estimate of net savings produced by the CBO shall serve as the savings target.

(2) UPDATED COST ESTIMATE REPORTS.—Starting on October 1, 2012, and every 2 years thereafter, through fiscal year 2019, OMB shall reestimate the budgetary effects of this Act based on the information available at that time. The updated cost estimate report shall include a detailed reestimate of the budgetary effects of this Act for the period 2010 through 2019, as well as information on the budgetary effects for the period 2020 through 2029.

(e) BIENNIAL SUBMISSION TO CONGRESS.—

(1) IN GENERAL.—Starting on October 1, 2012, and every 2 years thereafter, through fiscal year 2019, OMB shall submit the following to Congress along with its submission of the upcoming fiscal year budget of the United States Government required pursuant to section 1105 of title 31 of the United States Code:

(A) The updated cost estimate report completed pursuant to subsection (d)(2).

(B) An explanation of any discrepancies between the OMB updated cost estimate report and the updated advisory report prepared by CBO pursuant to subsection (c).

(2) REQUIRED INFORMATION UPON SAVINGS SHORTFALL.—For a fiscal year in which the amount estimated by OMB in its updated cost estimate report for the period 2010 through 2019 is less than the savings target, OMB shall also submit the following:

(A) Recommendations for increasing actual savings to or above the level of the savings target for years where the amount estimated under the updated cost estimate report is less than the savings target.

(B) An explanation of each recommendation.

(C) Proposed legislative language to carry out such recommendations (OMB proposal).

(D) Any other appropriate information.

(3) CONSIDERATIONS.—In developing and submitting the information required under paragraph (2), the OMB shall, to the extent feasible, give priority to recommendations that—

(A) preserve access to affordable health care;

(B) extend the solvency of the Medicare HI Trust Fund; and

(C) strengthen the long-term viability of the programs created under this Act.

(4) CONSULTATION WITH THE DEPARTMENT OF HEALTH AND HUMAN SERVICES AND CHIEF ACTUARY OF THE CENTERS OF MEDICARE AND MEDICAID SERVICES.—In carrying out this subsection, OMB shall consult with, including submitting a draft copy of any recommendations and legislation implementing such recommendations to, the Secretary of the Department of Health and Human Services and the Chief Actuary of the Centers of Medicare and Medicaid Services.

(f) EXPEDITED CONSIDERATION OF OMB PROPOSAL.—

(1) INTRODUCTION OF OMB PROPOSAL.—The OMB proposal shall be introduced in the House of Representatives and in the Senate not later than 5 days of session after receipt by the Congress pursuant to subsection (e), by the majority leader of each House of Congress, for himself, the minority leader of each House of Congress, for himself, or any member of the House designated by the majority leader or minority leader. If the OMB proposal is not introduced in accordance with the preceding sentence in either House of Congress, then any Member of that House may introduce the OMB proposal on any day thereafter. Upon introduction, the OMB proposal shall be referred to the relevant committees of jurisdiction.

(2) COMMITTEE CONSIDERATION.—The committees to which the OMB proposal is referred shall report the OMB proposal without any revision and with a favorable recommendation, an unfavorable recommendation, or without recommendation, not later than 30 calendar days after the date of introduction of the bill in that House, or the first day thereafter on which that House is in session. If any committee fails to report the bill within that period, that committee shall be automatically discharged from consideration of the bill, and the bill shall be placed on the appropriate calendar.

(3) FAST TRACK CONSIDERATION IN HOUSE OF REPRESENTATIVES.—

(A) PROCEEDING TO CONSIDERATION.—It shall be in order, not later than 7 days of session after the date on which an OMB proposal is reported or discharged from all committees to which it was referred, for the majority leader of the House of Representatives or the majority leader's designee, to move to proceed to the consideration of the OMB proposal. It shall also be in order for any Member of the House of Representatives to move to proceed to the consideration of the OMB proposal at any time after the conclusion of such 7-day period. All points of order against the motion are waived. Such a motion shall not be in order after the House has disposed of a motion to proceed on the OMB proposal. The previous question shall be considered as ordered on the motion to its adoption without intervening motion. The motion shall not be debatable. A motion to reconsider the vote by which the motion is disposed of shall not be in order.

(B) CONSIDERATION.—The OMB proposal shall be considered as read. The previous question shall be considered as ordered on the OMB proposal to its passage without intervening motion except 50 hours of debate, including the 2 amendments described in subparagraph (E), equally divided and controlled by the proponent and an opponent. A motion to limit debate shall be in order during such debate. A motion to reconsider the vote on passage of the OMB proposal shall not be in order.

(C) APPEALS.—Appeals from decisions of the chair relating to the application of the Rules of the House of Representatives to the procedure relating to the OMB proposal shall be decided without debate.

(D) APPLICATION OF HOUSE RULES.—Except to the extent specifically provided in this paragraph, consideration of an OMB proposal shall be governed by the Rules of the House of Representatives. It shall not be in order in the House of Representatives to consider any

OMB proposal introduced pursuant to the provisions of this subsection under a suspension of the rules pursuant to clause 1 of House Rule XV, or under a special rule reported by the House Committee on Rules.

(E) AMENDMENTS.—

(i) IN GENERAL.—It shall be in order for the majority leader, or his designee, and the minority leader, or his designee, to each offer one amendment in the nature of a substitute to the OMB proposal, provided that any such amendment would not have the effect of decreasing any specific budget outlay reductions below the level of such outlay reductions provided in the OMB proposal, or would have the effect of reducing Federal revenue increases below the level of such revenue increases provided in the OMB proposal, unless such amendment makes a reduction in other specific budget outlays related to Federal health expenditures, an increase in other specific Federal revenues related to Federal health expenditures, or a combination thereof, at least equivalent to the sum of any increase in outlays or decrease in revenues provided by such amendment.

(ii) SCORING.—CBO scores of the OMB proposal and any amendment in the nature of a substitute shall be used for the purpose of determining whether such amendment achieves at least the same amount of savings as the OMB proposal.

(iii) MULTIPLE AMENDMENTS.—If more than 1 amendment is offered under this subparagraph, then each amendment shall be considered separately, and the amendment receiving both an affirmative vote of three-fifths of the Members, duly chosen and sworn, and the highest number of votes shall be the amendment adopted.

(F) VOTE ON PASSAGE.—Immediately following the conclusion of consideration of the OMB proposal, the vote on passage of the OMB proposal shall occur without any intervening action or motion and shall require an affirmative vote of three-fifths of the Members, duly chosen and sworn. If the OMB proposal is passed, the Clerk of the House of Representatives shall cause the bill to be transmitted to the Senate before the close of the next day of session of the House.

(4) FAST TRACK CONSIDERATION IN SENATE.—

(A) IN GENERAL.—Notwithstanding rule XXII of the Standing Rules of the Senate, it is in order, not later than 7 days of session after the date on which an OMB proposal is reported or discharged from all committees to which it was referred, for the majority leader of the Senate or the majority leader's designee to move to proceed to the consideration of the OMB proposal. It shall also be in order for any Member of the Senate to move to proceed to the consideration of the OMB proposal at any time after the conclusion of such 7-day period. A motion to proceed is in order even though a previous motion to the same effect has been disagreed to. All points of order against the motion to proceed to the OMB proposal are waived. The motion to proceed is not debatable. The motion is not subject to a motion to postpone. A motion to reconsider the vote by which the motion is agreed to or disagreed to shall not be in order. If a motion to proceed to the consideration of the OMB proposal is agreed to, the OMB proposal shall remain the unfinished business until disposed of.

(B) DEBATE.—Consideration of an OMB proposal and of all debatable motions and appeals in connection therewith shall not exceed a total of 50 hours. Debate shall be divided equally between the majority and minority leaders or their designees. A motion further to limit debate on the OMB proposal is in order. Any debatable motion or appeal is debatable for not to exceed 1 hour, to be divided equally between those favoring and those opposing the motion or appeal. All time used for consideration of the OMB proposal, including time used for quorum calls and voting, shall be counted against the total 50 hours of consideration.

(C) AMENDMENTS.—

(i) IN GENERAL.—It shall be in order for the majority leader, or his designee, and the minority leader, or his designee, to each offer one amendment in the nature of a substitute to the OMB proposal, provided that any such amendment would not have the effect of decreasing any specific budget outlay reductions below the level of such outlay reductions provided in OMB proposal, or would have the effect of reducing Federal revenue increases below the level of such revenue increases provided in the OMB proposal, unless such amendment makes a reduction in other specific budget outlays related to Federal health expenditures, an increase in other specific Federal revenues related to Federal health expenditures, or a combination thereof, at least equivalent to the sum of any increase in outlays or decrease in revenues provided by such amendment.

(ii) SCORING.—CBO scores of the OMB proposal and any amendment in the nature of a substitute shall be used for the purpose of determining whether such amendment achieves at least the same amount of savings as the OMB proposal.

(D) VOTE ON PASSAGE.—The vote on passage shall occur immediately following the conclusion of the debate on the OMB proposal and a single quorum call at the conclusion of the debate if requested. Passage shall require an affirmative vote of three-fifths of the Members, duly chosen and sworn.

(E) RULINGS OF THE CHAIR ON PROCEDURE.—Appeals from the decisions of the Chair relating to the application of the rules of the Senate to the procedure relating to a OMB proposal shall be decided without debate.

(5) RULES TO COORDINATE ACTION WITH OTHER HOUSE.—

(A) REFERRAL.—If, before the passage by 1 House of an OMB proposal of that House, that House receives from the other House an OMB proposal, then such proposal from the other House shall not be referred to a committee and shall immediately be placed on the calendar.

(B) TREATMENT OF OMB PROPOSAL OF OTHER HOUSE.—If 1 House fails to introduce or consider a OMB proposal under this section, the OMB proposal of the other House shall be entitled to expedited floor procedures under this section.

(C) PROCEDURE.—

(i) OMB PROPOSAL IN THE SENATE.—If prior to passage of the OMB proposal in the Senate, the Senate receives an OMB proposal from the House, the procedure in the Senate shall be the same as if no OMB proposal had been received from the House except that—

(I) the vote on final passage shall be on the OMB proposal of the House if it is identical to the OMB proposal then pending for passage in the Senate; or

(II) if the OMB proposal from the House is not identical to the OMB proposal then pending for passage in the Senate and the Senate then passes the Senate OMB proposal, the Senate shall be considered to have passed the House OMB proposal as amended by the text of the Senate OMB proposal.

(ii) DISPOSITION OF THE OMB PROPOSAL.—Upon disposition of the OMB proposal received from the House, it shall no longer be in order to consider the OMB proposal originated in the Senate.

(D) TREATMENT OF COMPANION MEASURES IN THE SENATE.—If following passage of the OMB proposal in the Senate, the Senate then receives an OMB proposal from the House of Representatives that is the same as the OMB proposal passed by the House, the House-passed OMB proposal shall not be debatable. If the House-passed OMB proposal is identical to the Senate-passed OMB proposal, the vote on passage of the OMB proposal in the Senate shall be considered to be the vote on passage of the OMB proposal received from the House of Representatives. If it is not identical to the House-passed OMB proposal, then the Senate shall be considered to have passed the OMB proposal of the House as amended by the text of the Senate OMB proposal.

(E) CONSIDERATION IN CONFERENCE.—Upon passage of the OMB proposal, the Senate shall be deemed to have insisted on its amendment and requested a conference with the House of Representatives on the disagreeing votes of the two Houses, and the Chair be authorized to appoint conferees on the part of the Senate, without any intervening action.

(F) ACTION ON CONFERENCE REPORTS IN SENATE.—

(i) MOTION TO PROCEED.—A motion to proceed to the consideration of the conference report on the OMB proposal may be made even though a previous motion to the same effect has been disagreed to.

(ii) CONSIDERATION.—During the consideration in the Senate of the conference report (or a message between Houses) on the OMB proposal, and all amendments in disagreement, and all amendments thereto, and debatable motions and appeals in connection therewith, debate (or consideration) shall be limited to 10 hours, to be equally divided between, and controlled by, the majority leader and minority leader or their designees. Debate on any debatable motion or appeal related to the conference report (or a message between Houses) shall be limited to 1 hour, to be equally divided between, and controlled by, the mover and the manager of the conference report (or a message between Houses).

(iii) DEBATE IF DEFEATED.—If the conference report is defeated, debate on any request for a new conference and the appointment of conferees shall be limited to 1 hour, to be equally divided between, and controlled by, the manager of the conference report and the minority leader or his designee, and should any motion be made to instruct the conferees before the conferees are named, debate on such motion shall be limited to one-half hour, to be equally divided between, and controlled by, the mover and the manager of the conference report. Debate on any amendment to any such instructions shall be limited to 20 minutes, to be equally divided between and controlled by the mover and the manager of the conference report. In all cases when the manager of the conference report is in favor of any motion, appeal, or amendment, the time in opposition shall be under the control of the minority leader or his designee.

(iv) AMENDMENTS IN DISAGREEMENT.—If there are amendments in disagreement to a conference report on the OMB proposal, time on each amendment shall be limited to 30 minutes, to be equally divided between, and controlled by, the manager of the conference report and the minority leader or his designee. No amendment that is not germane to the provisions of such amendments shall be received.

(G) VOTE ON CONFERENCE REPORT IN EACH HOUSE.—Passage of the conference in each House shall be by an affirmative vote of three-fifths of the Members of that House, duly chosen and sworn.

(H) VETO.—If the President vetoes the bill debate on a veto message in the Senate under this subsection shall be 1 hour equally divided between the majority and minority leaders or their designees.

(6) RULES OF THE SENATE AND HOUSE OF REPRESENTATIVES.—This subsection is enacted by Congress—

(A) as an exercise of the rulemaking power of the Senate and the House of Representatives, respectively, and is deemed to be part of the rules of each House, respectively but applicable only with respect to the procedure to be followed in that House in the case of bill under this section, and it supersedes other rules only to the extent that it is inconsistent with such rules; and

(B) with full recognition of the constitutional right of either House to change the rules (so far as they relate to the procedure of that House) at any time, in the same manner, and to the same extent as in the case of any other rule of that House.

SA 3257. Ms. MURKOWSKI submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 352, line 8, strike ''50'' and insert ''500''.

On page 352, line 13, strike ''50'' and insert ''500''.

On page 352, line 16, strike ''50'' and insert ''500''.

On page 352, line 20, strike ''50'' and insert ''500''.

SA 3258. Mrs. SHAHEEN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 869, between lines 14 and 15, insert the following:

SEC. 3143. FLOOR ON AREA WAGE INDEX.

(a) IN GENERAL.—Notwithstanding any other provision of law, beginning with discharges occurring on or after October 1, 2009, for purposes of section 1886(d)(3)(E) of the Social Security Act (42 U.S.C. 1395ww(d)(3)(E)), the area wage index applicable under such section to hospitals with Medicare provider numbers 300001, 300003, 300005, 300011, 300012, 300014, 300017, 300018, 300019, 300020, 300023, 300029, and 300034 shall not be less than the post-reclassification area wage index applicable to the hospital for purposes of determining payments during the period beginning on or after October 1, 2006, and before October 1, 2007.

(b) IMPLEMENTATION.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall make a proportional adjustment in the standardized amounts determined under section 1886(d)(3) of the Social Security Act (42 U.S.C. 1395ww(d)(3)) to assure that the provisions of this section do not result in aggregate payments under section 1886 of such Act (42 U.S.C. 1395ww) that are greater or less than those that would otherwise be made. Notwithstanding any other provision of law, for purposes of making adjustments under this subsection, the Secretary shall not further adjust the wage index or standardized amounts for any area, State, or region within the United States.

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON AGRICULTURE, NUTRITION, AND FORESTRY

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Committee on Agriculture, Nutrition, and Forestry be authorized to meet during the session of the Senate on December 16, 2009.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON ARMED SERVICES

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Committee on Armed Services be authorized to meet during the session of the Senate on December 16, 2009, at 1:30 p.m.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Committee on Energy and Natural Resources be authorized to meet during the session of the Senate on December 16, at 11:30 a.m., in room SD–366 of the Dirksen Senate Office Building.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Committee on Homeland Security and Governmental Affairs be authorized to meet during the session of the Senate on December 16, 2009, at 10 a.m.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON THE JUDICIARY

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Committee on the Judiciary be authorized to meet during the session of the Senate on December 16, 2009, at 3 p.m., in room SD–226 of the Dirksen Senate Office Building, to conduct a hearing entitled ''Judicial Nominations.''

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON VETERANS' AFFAIRS

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Committee on Veterans' Affairs be authorized to meet during the session of the Senate on December 16, 2009.

The PRESIDING OFFICER. Without objection, it is so ordered.

SUBCOMMITTEE ON FEDERAL FINANCIAL MANAGEMENT, GOVERNMENT INFORMATION, FEDERAL SERVICES, AND INTERNATIONAL SECURITY

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Committee on Homeland Security and Governmental Affairs' Subcommittee on Federal Financial Management, Government Information, Federal Services, and International Security be authorized to meet during the session of the Senate on December 16, 2009, at 2:30 p.m. to conduct a hearing entitled, ''Tools to Combat Deficits and Waste: Enhanced Rescission Authority''.

The PRESIDING OFFICER. Without objection, it is so ordered.

SUBCOMMITTEE ON HUMAN RIGHTS AND THE LAW

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Committee on the Judiciary, Subcommittee on Human Rights and the Law, be authorized to meet during the session of the Senate on December 16, 2009, at 10:30 a.m., in room SD–226 of the Dirksen Senate Office Building, to conduct a hearing entitled ''The Law of the Land: U.S. Implementation of Human Rights Treaties.''

The PRESIDING OFFICER. Without objection, it is so ordered.

HONORING THE ESTABLISHMENT OF DIPLOMATIC RELATIONS BETWEEN THE UNITED STATES AND THE HASHEMITE KINGDOM OF JORDAN

Mr. DURBIN. I ask unanimous consent that the Senate proceed to the immediate consideration of S. Res. 376, submitted earlier today.

The PRESIDING OFFICER. The clerk will report the resolution by title.

The assistant legislative clerk read as follows:

A resolution (S. Res. 376) honoring the 60th anniversary of the establishment of diplomatic relations between the United States and the Hashemite Kingdom of Jordan, the 10th anniversary of the accession to the throne of His Majesty King Abdullah II Ibn Al Hussein, and for other purposes.

There being no objection, the Senate proceeded to consider the resolution.

Mr. INOUYE. Madam President, today, I am supporting this resolution to honor the 60th anniversary of the establishment of diplomatic relations between the U.S. and the Hashemite Kingdom of Jordan, as well as to honor the 10th anniversary of His Majesty King Abdullah II Ibn Al Hussein's accession to the throne. I am pleased to be joined in this endeavor by Senator GREGG.

Since establishing diplomatic relations, Jordan has worked together with the U.S. towards the mutual goal of peace in the Middle East. In 1994, King Hussein and Prime Minister of Israel, Yitzhak Rabin, signed the Jordan-Israel peace treaty, ending nearly 50 years of war between the two countries. The government of Jordan has been an instrumental partner in the fight against al-Qaida and terrorism. As a result, the people of Jordan have also suffered devastating losses at the hands of terrorists.

Mr. DURBIN. I ask unanimous consent to be added as a cosponsor to this legislation.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. DURBIN. I ask unanimous consent that the resolution be agreed to,

the preamble be agreed to, the motions to reconsider be laid upon the table, with no intervening action or debate, and any statements be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The resolution (S. Res. 376) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

S. RES. 376

Whereas the Hashemite Kingdom of Jordan achieved independence on May 25, 1946;

Whereas the United States recognized Jordan as an independent state in a White House announcement on January 31, 1949;

Whereas diplomatic relations and the American Legation in Jordan were established on February 18, 1949, when United States diplomat Wells Stabler presented his credentials as Chargé d'Affaires in Amman;

Whereas, for 60 years, the United States and Jordan have enjoyed a close relationship and have worked together to advance issues ranging from the promotion of Middle East peace to advancing the socio-economic development of the people of Jordan, as well as the threat to both posed by al Qaeda and violent extremism;

Whereas, from 1952 to 1999, King Hussein charted a moderate path for his country;

Whereas, for decades, the United States has been Jordan's strongest international partner;

Whereas, throughout his reign, King Hussein looked for opportunities to realize his dream of a more peaceful Middle East by working to solve intra-Arab disputes and engaging successive Prime Ministers of Israel in the search for peace;

Whereas King Hussein and Prime Minister of Israel Yitzhak Rabin signed the historic Jordan-Israel peace treaty in 1994, ending nearly 50 years of war between the neighboring countries;

Whereas the United States lost a close friend and a crucial partner when King Hussein passed away in 1999;

Whereas King Hussein was succeeded by his son, King Abdullah II, who has continued his father's work to improve the lives of the people of Jordan while also seeking to bring peace to the region;

Whereas, in the aftermath of the September 11, 2001, terrorist attacks, the Government of Jordan has been an instrumental partner in the fight against al Qaeda, has provided crucial assistance in Iraq, and has shouldered a heavy burden in providing refuge to a significant portion of the Iraqi refugee population;

Whereas, through his 2004 Amman Message, King Abdullah II has been a leading Arab voice in trying to reaffirm the true path of Islam;

Whereas, in November 2005, al Qaeda terrorists struck three hotels in Amman, Jordan, thereby uniting the people of Jordan and the United States in grief over the lives lost at this act of terrorism; and

Whereas King Abdullah II begins his second decade on the Hashemite throne by redoubling his efforts for peace in the region as the Jordan-United States partnership enters its seventh decade: Now, therefore, be it

Resolved, That the Senate—

(1) commemorates the 60th anniversary of the close relationship between the United States and the Hashemite Kingdom of Jordan;

(2) expresses its profound admiration and gratitude for the friendship of the people of Jordan;

(3) congratulates His Majesty King Abdullah II on 10 years of enlightened and progressive rule; and

(4) shares the hope of His Majesty King Abdullah II and the people of Jordan for a more peaceful Middle East.

ORDERS FOR THURSDAY, DECEMBER 17, 2009

Mr. DURBIN. I ask unanimous consent that when the Senate completes its business today, it adjourn until 10 a.m., Thursday, December 17; that following the prayer and pledge, the Journal of proceedings be approved to date, the morning hour be deemed expired, the time for the two leaders be reserved for their use later in the day, and the Senate resume consideration of the House message with respect to H.R. 3326, the Department of Defense appropriations bill, with Senators permitted to speak for up to 10 minutes each; provided further that the first hour be equally divided and controlled between the two leaders or their designees, with the Republicans controlling the first half and the majority controlling the second half.

The PRESIDING OFFICER. Without objection, it is so ordered.

ADJOURNMENT UNTIL 10 A.M. TOMORROW

Mr. DURBIN. Madam President, if there is no further business to come before the Senate, I ask unanimous consent that it adjourn under the previous order.

There being no objection, the Senate, at 6:21 p.m., adjourned until Thursday, December 17, 2009, at 10 a.m.